Research Dossier

Investigating the effectiveness of Acceptance and Commitment skills training for people with moderate public speaking anxiety via a randomised controlled trial of Group versus Self-help format

By

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ABSTRACT

Public speaking anxiety (PSA), widespread amongst students and also the general population, is associated with substantial distress and interferes with a person's ability to give a presentation or speech. This can lead to difficulties in social, occupational and academic areas of functioning. Despite its pervasiveness, very few individuals will seek help, most will tend to avoid the anxiety-provoking situations. This can be a serious issue if left untreated, leading to negative impacts on quality of life, for example dropping out of education early and subsequently having limited job opportunities. The literature review explored the existing body of work regarding PSA and presented the rationale for the current research, beginning with a conceptual framework and the manner in which PSA is related to Social Anxiety Disorder (SAD). This was followed by a detailed investigation of existing influential models and treatment modalities for both PSA and SAD. It identified that CBT has been the most effective treatment and has been delivered via different formats; however some individuals with SAD/PSA did not respond to a mainstream CBT approach and continued presenting residual symptoms after therapy. Thus, Acceptance and Commitment Therapy (ACT) was introduced, with an examination of its model and potential to help PSA. Preliminary research employing acceptance-based strategies have provided promising results. The literature review indicated a need for investigation of (i) more readily disseminated, briefer formats of ACT and (ii) whether differences exist in efficacy and sustainability between non-guided self-help and group-led therapies format. Given the large number of individuals experience PSA/SAD and the limited availability of resources, there is a need to consider ways of improving access. Thus, development of ultra-brief interventions would potentially reduce delivery cost and enhance dissemination to a larger population. Keywords: public speaking anxiety, social anxiety, interventions, experiential avoidance, fear of negative evaluation, acceptance.

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List of Abbreviations

ACT	Acceptance and Commitment Therapy
AAQ	Acceptance and Action Questionnaire
DSM	Diagnostic and Statistical Manual of Mental Disorders
EA	Experiential Avoidance
ET	Exposure Therapy
NICE	National Institute of Clinical Excellence
PSA	Public Speaking Anxiety
PRCS	Personal Report of Confidence as a Speaker Scale
RCT	Randomised Control Trial
RFT	Relational Frame Theory
SAD	Social Anxiety Disorder
SIAS	Social Interactions and Anxiety Scale
SST	Social Skills Training
VLQ	Valued living Questionnaire

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Introduction to research dossier

The research project contained within this research dossier is sub-divided into three chapters as follows: Chapter one provides a broad introduction to public speaking anxiety (PSA) and its impact upon the lives of individuals. It includes a conceptual literature review of relevant material that reflects both recent and historical developments in this field.

Chapter two comprises the empirical study, the design, logistical planning and implementation, finally an analysis and discussion of the results arising from the present study. Chapter three provides a critical appraisal and conclusions.

The conceptual literature review explores the existing body of work regarding PSA and its relation to Social Anxiety Disorder (SAD). This is followed by a detailed investigation of current influential models and treatment modalities for SAD and the implications for developing effective therapy for the amelioration of PSA. The review concludes with a critique of the research evidence. Methodological limitations are outlined, clinical implications and future research directions are discussed.

Weaknesses in existing treatment modalities are identified, in particular with regard to the potential risk of increasing the cognitive burden or overhead due to utilizing control and suppression based approaches. In order to address the additional stresses of an active approach to the management of PSA, the Acceptance & Commitment Therapy (ACT) model is introduced. This model readily lends itself to the development of acceptance and mindfulness based approaches to the management of PSA which do not place an additional cognitive burden upon the individual experiencing PSA.

The empirical study explores the effectiveness of an ultra-brief Acceptance and Commitment Therapy for PSA using a randomized control trial where a self-help workbook-based intervention was compared with a group-based intervention. The results are discussed in detail, in relation to the existing evidence and the potential for further investigation. The findings of this study are shown to provide supportive evidence for the efficacy of the ACT approach in reducing PSA and associated avoidance behaviour. There is also evidence suggesting a promotion of increased flexibility and willingness to engage in previously feared public-speaking situations. Further, this study found that a self-help intervention was equally as effective as a group format in relation to PSA.

The critical appraisal incorporates considered reflections of the author in relation to the training in counselling psychology and doctoral research process and associated experiences.

Chapter One: Literature Review

1.0 Overview

Public speaking as reported by the wider general population may be considered a common fearful social situation. Across all social strata, prevalence rates for Public Speaking Anxiety (PSA) have been reported to range from 20% (Ruscio, Brown, Wai, Jitender, Murray, & Ronald, 2008) to 70-80% (Motley, 1997; Knappe, Beesdo-Baum, Fehm, Murray, Roseline, & Hans, 2011). Individuals with PSA may typically fear being the focus of attention and critical assessment by others. They may experience unhelpful cognitions, physiological arousal and behavioural avoidance of public speaking situations, which can negatively impact everyday functioning (Herbert & Dalrymple, 2005; Stien, Walker, & Forde, 1996; National Institute of Health & Care Excellence (NICE), 2013).

For many people, and in particular for university students, public speaking is a frequent and recurrent task and competency is often a necessary requirement for working/academic life (Bogels & Tarrier, 2004; Furmark, Tillfors, Everz, Marteinsdottir, Gefvret, & Fredrikson, 1999; Lopez, Bedmar, & Moreno, 2013; Tillfors, Carlbring, Furmark, Levenhaupts, Spak, Westling, & Andersson, 2008). Existing research has already demonstrated that high levels of PSA can have an extremely debilitating effect, impacting upon performance within social, domestic and work-related settings (Aderka, Hofmann, Nickerson, Hermesh, Gilboa-Schechtman, & Marom, 2012; Clark & Wells, 1995; Herbert & Dalrymple, 2005; Stien et al.1996).

Correlational data has suggested that PSA is a significant factor for increased risk of social impairment, unemployment, lower income and academic under-achievement within the general population (Aderka et al., 2012). Individuals with PSA may actually be unaware of

how much this is impacting upon their day-to-day tasks, in terms of ordinary life-skills that others take for granted. Choices of jobs may be unwittingly limited and otherwise potential avenues for promotion closed to them. At the clinical level, public speaking anxiety can be specified as a form of social anxiety disorder (SAD) (American Psychiatric Association, 2015) in which social interactions may become too painful to contemplate thus resulting in anger, isolation, distress, frustration, and even clinical depression (Aderka et al., 2012; Lopez, Bedmar, & Moreno, 2013; Crozier & Alden, 2005; Kessler, Berglund, Demler, Jin, Merikangas, & Walters 2005).

Figure-1 below illustrates areas of day-to-day life likely impacted upon by a social anxiety disorder with PSA being most likely to have significant impacts upon long-term quality of life when encountered within a work/academic-related setting. This is typically due to societal expectations around career progression. By way of contrast, whilst PSA may be experienced in the context of making a formal speech at a large family gathering, it is unlikely in isolation to cause severe long-term quality of life issues if the person is not distressed by it (NICE, 2013).

The focus of this review is to present a broad review of current literature regarding PSA and to present the rationale for the research. It begins with a theoretical framework and the manner in which PSA is related to social anxiety; this is followed by a detailed exploration of, what are currently the most influential models and treatment modalities for PSA and general social anxiety. Next, there is a more in-depth introduction to the ACT model and its application in relation to PSA. The chapter concludes with a detailed critique of research evidence that is relevant to the present study and the summary.

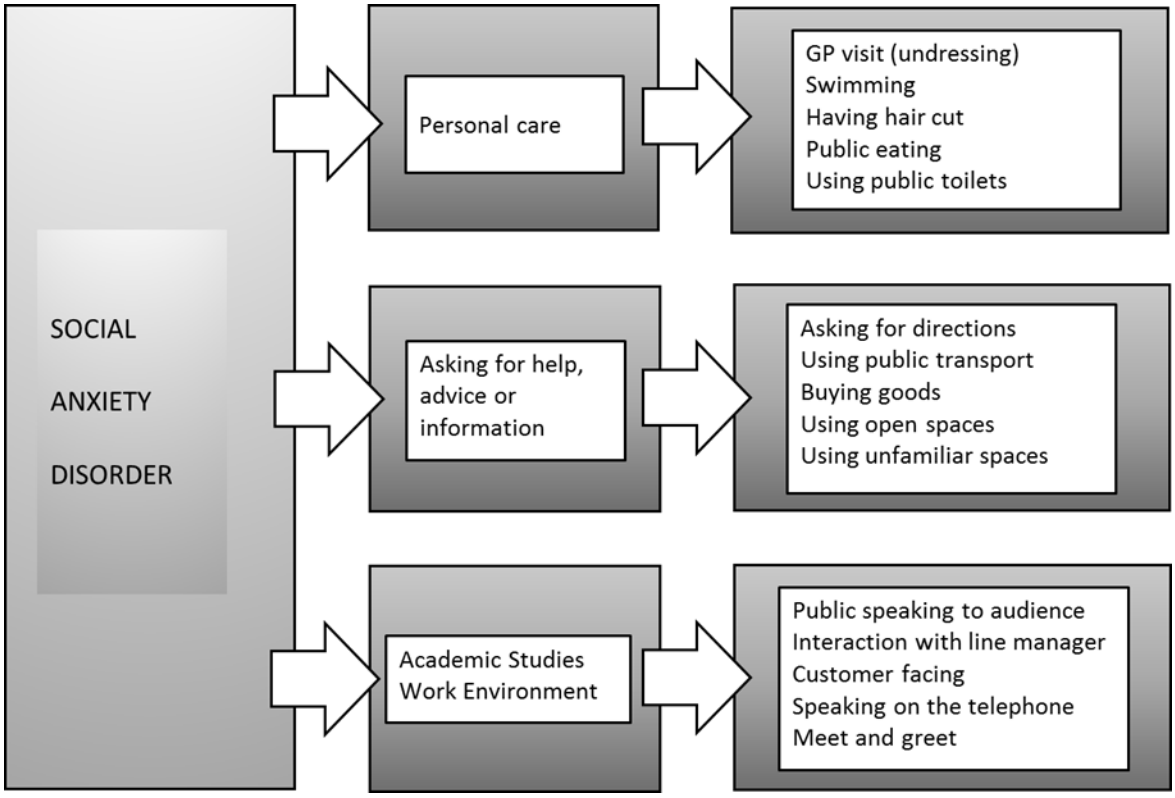


Figure-1: Activities that may be adversely impacted by social anxiety (NICE, 2013)

1.2 PSA and its link to SAD

PSA is considered to be the most common form of SAD of a specific (non-generalized) type (Blote, Duvekot, & Schalk, 2010) meaning it is an anxiety restricted to a fear of public speaking and that it does not necessarily co-occur with other social anxiety forms (Blote et al., 2010).

Otherwise well-adjusted individuals can often exhibit moderate anxiety from simply thinking about the task of public speaking. It is frequently reported as a common feared social situation (Aderka et al., 2012; NICE, 2013). Mild levels of PSA may be attributed to natural shyness in an individual or a healthy "fight or flight" response for the individual facing a relatively large group of people (Crozier & Alden, 2005). This natural response

may have very little impact upon an individual's life, evidenced perhaps by only hesitance or a reluctance to speak rather than actual avoidance.

Alternatively, PSA may be more pronounced and depending on the severity and/or complexity might also be co-morbid with other more specific phobias (Aderka et al., 2012). In the extreme, individuals with PSA may also be diagnosed with social anxiety disorder (SAD) which is an anxiety disorder associated with significant impairment, psycho-social distress, and co-occurring psychological disorders such as depression (Rapee & Lim, 1992); increased suicide (Crozier & Alden, 2005); substance misuse (Maggee, Eaton, Wittchen, Fuetsh, Mcgnagle, & Kessler, 1996) and avoidant personality disorder (Hope & Heimberg, 1993). The Diagnostic and Statistical Manual of Mental Disorders (5th ed., text revision; (DSM-VTR; NICE, 2013) defines SAD as a marked apprehension and fear of embarrassment in social situations in which the individual is exposed to possible scrutiny by others and where the disorder is characterized by avoidance of such situations. Those social situations involve interaction, performance and observation such as giving a speech in groups, talking to authority figures, dating, and being observed while working/performing (NICE, 2013 p.19).

The DSM-V sub-divides social phobia into two distinct types: generalized and non-generalized or specific. The former includes a fear of multiple social situations with avoidance behaviour, which can be considered as disabling, whilst the non-generalized subtype includes fear of one or two discrete social situations with avoidance behaviour for example public speaking and test anxiety (Blote, 2010).

Social anxiety responses can be divided into three categories, physiological, cognitive and behavioural responses. Physiological responses may include trembling, blushing, sweating,

quivering voice, and muscle tension (Crozier & Alden 2005). Cognitive responses include negative self-appraisal such as “I am a failure” and attentional biases such as “People will notice my shaking.” Inappropriate worrying about other`s negative evaluations and disapproval is common, for example “People will think that I am stupid.” Behavioural responses to alleviate embarrassment and fear range from flat refusal to give a speech, through avoidance strategies which reduce the probability of having to give a speech, to the development of automatic mannerisms or knowingly applied techniques designed to hide fearfulness of negative evaluation and embarrassment whilst talking to an audience. This might include avoiding eye contact or gripping tightly onto something to conceal shaking (Acarturk, Cuijpers, van-Straten, & de Graaf, 2009). Whilst the aforementioned responses can be seen in other anxiety disorders, with regard to SAD, these responses are clearly related to recollection and/or anticipation of an actual social or performance situation (Stravinsky, 2007).

The cognitive (self-consciousness, fearing negative evaluation) and physiological (blushing, sweating, trembling) symptoms of social anxiety disorder (SAD) are all typical features of PSA. However, it should be borne in mind that a person who is fearful of the possibility of speaking in public may not, quite properly, receive a diagnosis of social phobia if public speaking is not actually to be encountered as distress. Therefore it is the level of distress or impairment concerning actual activity that determines a diagnosis of social phobia (Stein & Heimberg, 2009; NICE, 2013).

1.3 Prevalence of SAD and PSA

Quoted prevalence rates of SAD may differ from source to source due to the variability in the measurements used for diagnosis. According to NICE guidelines (2013), social anxiety

has a lifetime prevalence of 3% to 13%. In line with this, the National Co-morbidity Survey in the USA, with a sample of 9,282 English-speaking participants, reported a lifetime prevalence of 12% (Kessler et al., 2005). Furthermore, Stien & Kean (2000) found that in a USA community sample, the lifetime prevalence of social anxiety was 13% which included 7% for specific speaking fears and 5.9% for generalized social phobia. In a European sample, that included 18,980 individuals from Germany, UK, Italy, Portugal, and Spain (1994-1999). Ohayon & Schatzberg (2010) found that social anxiety occurred in 4.4% of the population. This research study found that the prevalence rate was higher for specific fears than for non-specific social anxiety; for example 6% for a fear of public speaking and taking meals in the presence of others and 5.4% for a fear of saying foolish things or being unable to answer questions in formal presentations.

Epidemiological studies of SAD have shown it to be more prevalent for women compared to men (Acarturk et al., 2009; Kessler et al., 2005; NICE, 2013). However in clinical settings, SAD was found to be equally common for both males and females (NICE, 2013).

To date, there is no UK survey particularly reporting data on adults particularly with PSA however some European countries have included the prevalence rate of PSA within their general population survey. Furmark et al (2000) found that 5.9% of individuals (among Swedish university students) with PSA were diagnosed with a non-generalized type (specific) form of social phobia (according to the DSM-IV) (Furmark, Tillfors, Stattin, Ekselius, & Fredrikson, 2000). Knappe et al (2011) had reported 6.5% occurrences of PSA as an isolated fear in approximately 70.3% of SAD patients (Knappe, Beesdo-Baum, Fehm, Murray, Roseline, & Hans, 2011).

Stien et al (1996) conducted a community sample study to investigate the prevalence and impact of PSA on an individual's daily functioning. This study utilized a randomized telephone survey with 499 community participants. It was found that one third of the respondents had reported that they experienced excessive anxiety when they spoke to a large audience. They also found an increased level of PSA often interfered with cognitive functioning by impairing the individual's ability to focus on their speech, form sentences, and think clearly. The reported impact upon participants included fearing the following adverse situations: one's mind going blank (74%); doing or saying something embarrassing and humiliating (64%); feeling unable to continue talking (63%); producing a nonsensical jumble of words (59%) and trembling and shaking (80%) (Stien et al., 1996).

1.4 Impacts of SAD and PSA

Recent correlational studies have demonstrated that social anxiety is more widespread in society than commonly believed, typically arising in childhood or adolescence (Aderka et al., 2012; Lopez et al., 2013 & Acarturk et al., 2009).

Fearfulness about a variety of social situations involving actual or perceived observation and/or evaluation can lead individuals to avoid the feared situation which over time can have a detrimental effect upon an individual's life by interfering significantly with their personal lives in areas such as occupational, social and academic functioning (Herbert & Dalrymple, 2005).

There has been recent research suggesting that individuals with generalized social anxiety do report greater difficulties in social, academic, interpersonal, work life as compared with those experiencing non-generalized types (Aderka et al., 2012). Further, SAD is often co-morbid with other psychological problems such as anxiety, depression and substance abuse

(Magee et al., 1996). Social anxiety can interfere with wide range of everyday activities such as talking on the phone, doing shopping, job interviews, dating etc. The majority of people experiencing SAD were found to be in employment but to be less productive at their place of work due to their symptoms (NICE, 2013). They would report having difficulties in forming close relationships (Aderka et al., 2012); to have less quality of life (Aderka et al., 2012) and even preferring to leaving employment if it involved public speaking (Aderka et al., 2012). In addition, SAD is associated with lower academic achievement when compared to individuals without SAD or the more specific PSA (Aderka et al., 2012).

The consequences of PSA are most likely to be felt in day-to-day working-life, for example an individual's educational achievement and career progress can be undermined (Blote, Duvekot, & Schalk, 2010). PSA is highly associated with risk of poor work productivity, poor academic achievements and dropping out of school early (NICE, 2013). Research shows that PSA is also associated with increased alcohol consumption and other substances within students to manage their anxiety (Lopez et al., 2013).

Work-place and higher education anxieties in these difficult economic times are understandably pervasive. There are strong societal expectations placed upon individuals, to be successful and to be seen to be successful. Anxieties around the work-place and academic arena are most likely to be intensified during public speaking. Not only is the individual's reputation at stake but there is the added pressure of being seen as an effective "team-player" and the responsibility of not letting down teaching staff, peers or work colleagues (NICE, 2013).

Despite the negative impacts of SAD/ PSA upon individuals, half of such adults reported not seeking treatment and continuing to endure difficulties (NICE, 2013). Actual and

perceived barriers to treatment include: poor recognition of SAD/PSA by mental health professionals, high costs of training/supervision of therapists, logistical difficulties and financial barriers such as time and cost (Yuen, Herbert, Forman, Goetter, Comer, & Bradley, 2010). Individuals are often uncertain about where to seek help; have concerns regarding social stigmatization and a fear of negative evaluation from their peers and even heath care professionals. Olfson et al (2000) found that the socially anxious individual will often feel ashamed and embarrassed about disclosing their psychological distress to work colleagues, family members, friends and health care professionals (Olfson, Guardino, Struening, Schneier, Hellman, & Klein, 2000). In order to conceal the undesired private experiences (cognitive, emotive and sensory) that accompany the anxiety, individuals will often either fail to seek psychological help or delay seeking professional help until there are much more severe complications. Unfortunately, failure to deal with work-place or school anxieties around performance in a timely manner can result in the loss of significant opportunities within higher education or the sphere of full-time work where a lost promotion or the loss of a job can be devastating.

A UK study conducted by Patel and colleagues (2000) evaluated the economic implications of SAD for both individuals and health care providers. They used the Adult Psychiatry Survey to collect their data. Their findings suggested that individuals with SAD were more likely to be within a low socio-economic group, had lower employment and low academic achievements (NICE, 2013; Patel, Knapp, Henderson, & Baldwin, 2002). With regards to the UK health care cost, there was a relatively low health care cost incurred by people experiencing SAD alone, which may indicate under-utilization of health services due to obstacles such as stigma and the associated embarrassment (NICE, 2013, p.30). However, they found that there was a higher health cost for dealing with SAD co-morbid with other

conditions; these higher costs that were incurred included the following, GP home visits, counselling fees and social security benefits payments (NICE, 2013).

It might be argued that for individuals experiencing SAD with no co-morbidity that if there is a relatively low immediate health care cost associated with this group then there is no need to target this population with therapy. However, despite the reported low health care cost, given the pervasive and long-lasting negative effects of SAD upon individuals, over the long-term there is an indirect cost arising from low academic achievement leading to reduced work productivity; further, long term psychological stress from the frustrations of a reduction in quality of life may manifest physiological illness later in life (NICE, 2013). Thus there can be significant long-term impacts for both the individual at risk and for wider society in terms of demographic pressures. In order to counter these future impacts, it is essential to begin to develop appropriate tools in the shape of effective, easily accessible psychological interventions using different modes of delivery e.g. brief self- help, group.

Before evaluating the efficacy of the psychological interventions, the next section will examine the aetiology and relevant theories of SAD that are also applicable to PSA and which inform current therapy modalities.

1.5 Aetiology

PSA as a sub-set of SAD is likely to share much of the same aetiology but the individual will tend to manifest overt symptoms under much more specific circumstances. Unlike the individual with SAD experiencing constant anxiety about multitudinous aspects of life, the individual with PSA experiences something akin to a step-change in anxiety level arising from planning and delivery of a public speaking exercise. A rapid intensification of anxiety tends to overwhelm the individual contemplating public speaking. It may derive from a

combination of both historical and current factors, for example previous bad experiences of public speaking and/or the pressure to perform in a professional setting without letting colleagues down. Such "trigger" stressors are commonly encountered within the work-place/study environment with the anxiety level returning reasonably quickly to a manageable baseline after the event (Blote, 2009).

The aetiology of SAD is multi-factorial and is well described in the literature. Suggested typical vulnerability factors include: traumatic life events (Crozier & Alden, 2005); family and socio-cultural factors (Crozier & Alden, 2005; Reich &Yates, 1988); personality factors such as avoidant personality acquired during childhood and characterised by behavioural inhibition, shyness (Crozier & Alden, 2005) for example when under pressure to perform well whilst being observed (Aderka et al., 2012). Whilst there are common vulnerability factors, it is the degree to which an individual's innate confidence has been repeatedly challenged by adverse life events combined with their own innate resolve to overcome such problems that will determine how problematic any anxieties will be to deal with in later times.

Common psychological theories and models (detailed below) used to explain and treat SAD, which is also applied to PSA (NICE, 2013; England, Herbert, Forman, Rabin, Juarascio, & Goldstein, 2012) are based upon cognitive-behavioural approaches including the cognitive therapy model (Beck, Emery, & Greenberg, 1985), social deficit models (Herbert, 1993) and the exposure model (Emmelkamp, Mersch, Vissia, & Van der Helm, 1985). Cognitive behavioural approaches highlight the role of certain cognitive processes such as distorted or biased cognitions in processing social cues; anticipatory and post-event processing; self-focused attention; negative expectations, assumptions and self-schemas (Clark & Wells, 1995). Behavioural factors also play an important role in the development and maintenance

of social anxiety for example, avoidance of public speaking and performance-related situations (Clark & Wells, 1995).

In relation to the formal diagnosis of social anxiety disorders, a detailed explanation of such assessments is beyond the scope of this review albeit, the main assessment tools to measure social anxiety involve a clinical interview following an administration of social anxiety scale evaluation such as the Social Interaction Anxiety Scale (SIAS) or the Liebowitz Social Anxiety Scale.

The following section will review the two major theories of SAD: Clark & Wells (1995) together with Rapee & Heimberg (1997), these currently inform existing treatment modalities.

These models of SAD are also applied to PSA and used to inform current treatment. As discussed previously individuals with generalized SAD do also experience PSA (Knappe et al., 2011, (DSM-V, 2015, NICE, 2013). Psychological interventions for generalized social anxiety are also utilized for its subtypes including public speaking anxiety (NICE, 2013). However psychological interventions for fear of public speaking may focus on the specific difficulties pertaining to the fear of speech and other responses such as anxious cognition, avoidance behaviour and physiological responses for example blushing and sweating.

1.6 Key Cognitive Models

Cognitive models of SAD emphasise the cognitive and behavioural factors in the development and maintenance of both SAD and PSA. These models are derived from an earlier model of anxiety as described by Beck, Emery & Greenberg (1985), which proposed that unhelpful cognitions can both manifest and maintain anxiety. These unhelpful

cognitions for example that people are going to be judgmental can create an "information processing bias" in relation to a perceived threat associated with social situations (Wells, 2007, p.169).

This biased thinking increases anxiety and reinforces beliefs pertaining to threat and thus causes individuals to focus more intently on the negative feedback from their environment and which in turn negatively influences internalised mental representations of their appearance and behaviour (Wells, 2007). This has the effect of triggering avoidant behaviour which in turn reduces opportunities to challenge and disconfirm biased beliefs.

Similarly, Hartman (1983, 1986, as cited in Wells, 2007) proposed a cognitive model of social anxiety which postulated that individuals with social anxiety are generally preoccupied with their thoughts in relation to their physical symptoms, social performance and other people`s perceived negative perceptions of them. Thus by increasingly dwelling on falsely-weighted assumed perceptions by others, creates a self-fulfilling prophecy as the intensity of feeling increases (cited in Wells, 2007).

It was Clark &Wells (1995) later followed by Rapee & Heimberg (1997) who introduced widely adopted, advanced cognitive models of social anxiety. Although they appear similar in their conceptions of social anxiety in which they focus on an individual's self-appraisals, attentional strategies and safety behaviours, a key difference between them is in the focus of how the anxiety is generated (Wells, 2007).

Clark & Wells (1995) focused predominantly on the cognitive and behavioural aspects of SAD whereas Rapee & Heimberg (1997) focused on the genetic predispositions and biological factors of SAD. Appraisals or evaluative expectations of others in social situation

are also highlighted in this model. This is an important point as understanding how PSA might be triggered will be key to the development of an appropriate countering strategy.

1.6.1 Clark & Wells (1995) Model

This model is based upon a cognitive model (Beck et al., 1985) and uses "information processing theory" (Clark & Wells, 1995) which is depicted diagrammatically in figure-2 below and illustrates the role of unhelpful appraisals/core beliefs and safety behaviours in the development and maintenance of the social anxiety problem.

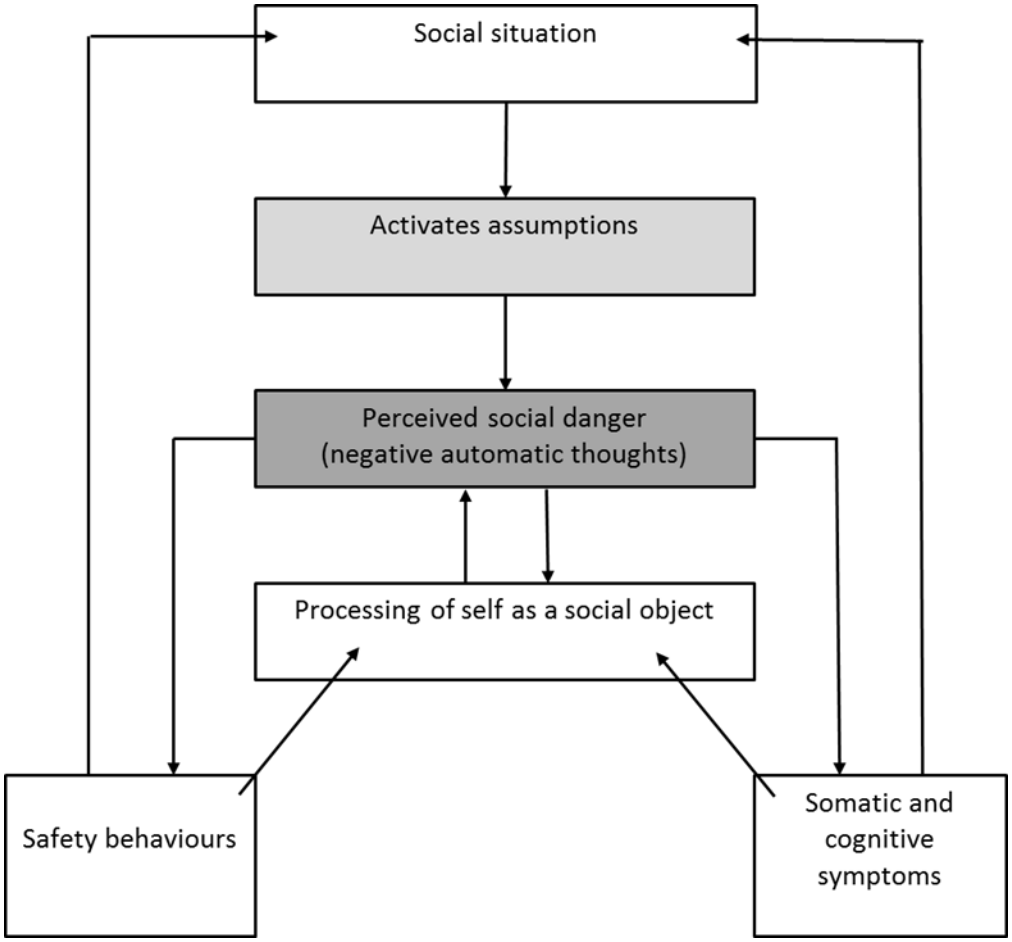


Figure-2. Cognitive Model of Social Phobia, Clark & Wells (1995)

The Clark & Wells (1995) model is used to explain that negative appraisals and beliefs are maintained by the following processes:

(I)- "Increased self-attention" meaning an extensive preoccupation with one's internal information rather than evaluating external aspects of the social situation.

(II)- "Use of misleading internal information/experiences" derived from feelings, thoughts and bodily sensations to make negative inferences about how one appears to others.

III- "Extensive use of safety behaviours" such as avoidance, substance abuse, even overt verbal aggression, that are strategies intended to manage a feared situations and hide or mask anxiety symptoms.

IV- "The use of the biased anticipatory-processing and post-event processing" so that after the situation has passed, engaging in ruminating over details of perceived negative aspects of the social encounter together with other past failures, negative images and predictions of poor performance leading to anticipatory worry regarding future events (Wells, 2007).

The Clark & Wells (1995) model further assumes that these negative self-perceptions and anxious thoughts do not fade over time but are actually retained in long-term memory since they can be recalled in detail.

Wells (2007) provides a useful explanation to elucidate these processes, as follows: upon encountering a challenging social situation, susceptible individuals will perceive the situation as dangerous, conceiving that they are at risk of acting in an unreasonable or

incompetent way and which they believe will negatively affect their self-concept and social status. Such an appraisal of danger may elicit physiological, cognitive, affective and behavioural responses leading the individual to become even more self-focused, shifting their attention further away from the actual situation and toward increased introspection. For example, they may engage in detailed self-observation, monitoring physical reactions that are likely to be viewed as particularly visible to others. This leads to actively engaging in negative self-processing, negative predictions such as having a self-perception of being uninteresting, boring to others and/or having educational inadequacies. The intended goal of this active self-observation and monitoring is to ensure that perceived (real or imagined) social expectations are met according to their own criteria such that she/he would be able to avoid the negative evaluation of others (Wells, 2007). This heightened resource-intensive self-attention focus will in fact tend to impede an individual's cognitive ability to assess and monitor the external aspects of their troubling social situation objectively. For example, it is suggested that such persons with social anxiety do demonstrate a marked negative bias towards detecting perceived negative audience responses such as yawning, whilst actually disregarding positive audience behaviours such as affirmative nodding and appropriate smiling (Veljaca & Rapee, 1998). Thus, the domination of unhelpful, dysfunctional inferences and predictions made with regards to how one is perceived by others contributes to and reinforces the vicious circle that develops and maintains (see figure-3 below) the social anxiety.

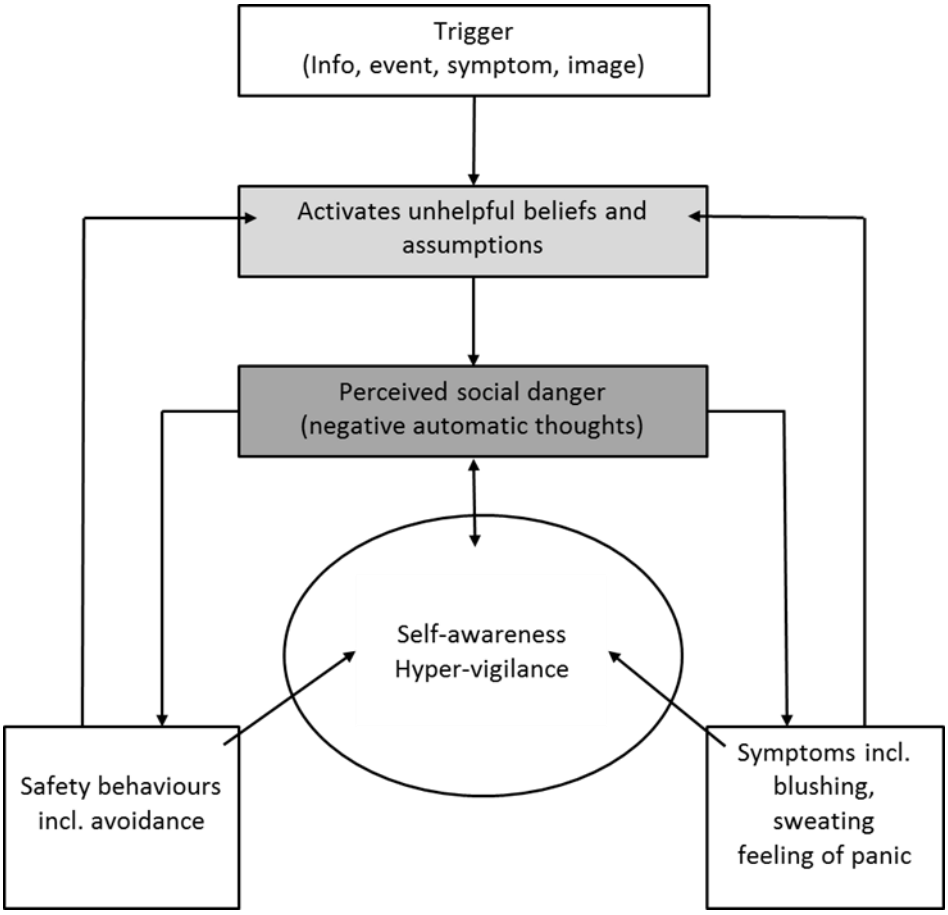


Figure-3. SAD/PSA Maintenance cycle

In order to avoid perceived social danger and to avert the feared social situation represented in negative thoughts, individuals will engage in safety behaviours which post-event are followed by rumination leading to further social apprehension in the future (Wells, 2007).

Safety behaviours can be divided into three categories (i) pre-meditated avoidance of a future event such as public speaking to reduce the risk of humiliation; (ii) escape from unexpected situations requiring an impromptu presentation by making hasty excuses;
(iii) engaging in pre-event or within-event behaviours to overcome performance anxiety and which might include over-rehearsal of materials, consumption of alcohol or illicit street

drugs to ease anxiety and the use of camouflage techniques such as holding a cup to conceal shaking hands (NICE, 2013, Salkovskis, Clark, Hackmann, Wells, & Gelder, 1999).

Counter-intuitively, so-called safety behaviours are actually considered the main contributory factors in maintaining and prolonging social anxiety (Wells, 2007). Firstly, safety behaviours prevent individuals from benefiting from disconfirmation and removes opportunities for testing negative beliefs which increases the frequency and strength of anxiety and self-focused attention (Wells, 2007). Secondly, safety behaviours provide negative reinforcement by bringing temporary relief through minimising contact with stimuli that elicit anxiety. However, long term, these behaviours are restrictive, narrowing behavioural repertoire, limiting opportunities by default through elimination of an otherwise preferred beneficial choice and acceptance of a limiting but "safe" choice, thus reinforcing inappropriate ideation and associated safety behaviours (Hooper, Stewart, Duffy, Freegard, & McHugh, 2012).

1.6.2 Rapee & Heimberg Model (1997)

Rapee & Heimberg (1997) proposed that individuals with social anxiety tend to actively search their social environment for any threats particularly in relation to the perceived risk of negative evaluation, an assumption which comes at the cost of intensified self-monitoring behaviour. They also attach far more emphasis on the positive appraisal of others arising from the schema/assumption developed from earlier life (Wells, 2007). This model postulates that persons with social anxiety may begin life with overprotective and intrusive parents who may continuously transfer their own anxiety onto their children about how the evaluation of others are highly important. Such parents encourage excessive concerns about evaluation of others and reinforce the idea that one is not competent enough to meet social

challenges and to attain the status-driven expectations of life. Individuals that have experienced intrusive parenting may therefore develop two major assumptions (schemas) about themselves and others (Heimberg, Liebowitz, Hope, Schneier, Holt, & Welkowitz 1998).The first assumption is that people inherently tend to evaluate others in a critical and negative manner. The second assumption is that being positively judged or appraised by other has fundamental importance (Heimberg et al., 1998).

According to this model, a person with social anxiety, when approaching a feared social situation will have an image of themselves based on her/his negative self-beliefs and beliefs about how others see them (observer-perfective as seen through the eyes of others). This increases the amount of attention focusing on the external cues to find the aspects of the environment that could potentially indicate negative evaluations emanating from their audience such as yawning indicating boredom; the audience whispering amongst themselves or facial affects such as frowning (Heimberg, Juster, Hope, & Mattia, 1995). This leads to controlled- based engagement in an overly-detailed self-monitoring of their own behaviours and perceived physical appearance such as blushing, tremulous voice, sweaty hands, defensive posture and trembling knees. Thus, the individual becomes increasingly distracted from the task at hand by the effort of this constant switching of focus and the interplay between scanning the outer environment and internal monitoring. Unwittingly, by adopting such controlled based- strategies leads to significant interference with social performance by inhibiting the individual`s ability to focus completely on the social tasking progress (Heimberg, et al., 1995).

Rapee & Heimberg (1997) argued that if the person believes that their social performance is below their self-expectations or simply poor, the tendency is to assume that they will be negatively evaluated by others. This negative interpretation leads to an escalation in anxiety-

evoking cognitive, behavioural and physiological responses which contribute to reinforcing the vicious circle thus maintaining or increasing the social anxiety.

In support of this model, other research has shown that the socially anxious person will indeed demonstrate a bias towards actively seeking out negative audience behaviours such as yawning whilst disregarding many positive audience responses such as attentive listening, affirmative nodding and smiling (Veljaca & Rapee, 1998, Bogel & Mansell, 2004).

1.6.3 Overview and Critique of Key Models

Clark & Wells (1995) and Rapee & Heimberg (1997) have both suggested that those with SAD have high standards in regard of how they think they should appear and perform in social situations; they will create a mental image of themselves based on their own negative self-beliefs and their perceptions of how others must see them. This personal self-image is then compared negatively to images of other people. They also have negative self-beliefs/inferiority about their abilities and a strong belief that negative outcomes will occur if they appear or perform poorly in front of others. This intense focus on self-image, presentation and perceived critical observation by others is at the heart of the problem for individuals experiencing PSA (Wells, 2007). As a consequence, social situations are perceived to be dangerous (through ridicule, looking foolish, loss of status) which creates intense anxiety (Heimberg et al., 1995). Both models have also highlighted the role of attentional biases that occur before, during and after a social situation and other factors such as the influence of past experiences of social events and the role of increased self-focus and feeling self-consciousness. The key difference between these models is the manner in which anxiety is accelerated (Roemer & Orsillo, 2009).

Clark & Wells (1995) suggested that negative self-appraisals and inferences induce anxiety, such that individuals diagnosed with SAD have a tendency to become further self-focused particularly with their own behaviours and physiological responses. This excessive internal focus inhibits a person's ability to pay sufficient attention to the actual social task required (Roemer & Orsillo, 2009).

According to Rapee & Heimberg (1997), however, it is external threat-monitoring which plays a major role in social anxiety disorder as the individual uses excessive attentional resources to scan the audience or social group for signs of potential negative evaluation such as yawning, frowning or staring. It is clear that the combined effort of both intensive internal focus and constant scanning of the external audience will come at some cost in respect of the quality of their interactions and delivery of the task at hand.

There is a body of research in support of the cognitive models reviewed above. Some research suggested evidence supporting the relationship between social anxiety and specific biases in information processing/judgement and attention (Roemer & Orsillo, 2009; Well, 2007). For example with regards to biases in information processing, socially anxious individuals have been found to use internal cues such as physiological arousal (blushing, sweating) to arrive at negative inferences or judgments concerning how they likely appear to others (Mellings & Alden, 2000; Wells & Papageorgiou, 2001). With regard to self-attention, individuals with SAD have, during social situations, shown to score highly on such measures (Heimberg et al., 1995, Mellings & Alden, 2000). They have also been found to be quick in detecting perceived negative responses from observed audience behaviours (Veljaca & Rapee, 1998).

Nevertheless, the research mentioned above is generally consistent with cognitive models of SAD/ PSA which attributes fear of public speaking to negative selection bias in relation to social performance. There is evidence to support these aforementioned models. Although it is important to note that there is no established evidence to show the role of cognitive biases and variables in the aetiology and maintenance of the disorder (Heimberg et al., 1998). Some critics have argued that biased information processing can be a consequence of social anxiety, rather than a cause (Roemer & Orsillo, 2009).

Cognitive-behavioural interventions for the treatment of SAD are based on the theories reviewed above. Cognitive reappraisal is used to modify dysfunctional cognitive processes as well as to assist in decreasing reliance upon avoidance behaviours, to break the maintenance cycle involved in SAD. (Sections 1.9.1 and 1.10 will discuss cognitive behavioural treatment and efficacy in detail).

Despite best efforts, many individuals treated for social anxiety will experience an incomplete recovery, displaying residual symptoms at treatment cessation (Heimberg et al., 1995; Herbert et al., 2005). There is thus scope for improvement of both the understanding of the processes deemed to underlie SAD (by association PSA also) and the manner in which the research is applied to the subsequent development of treatment modalities for both SAD and PSA.

Any opportunity to increase the resilience of the individual experiencing PSA must be exploited as it must always be borne in mind that typically for such an individual, they will continue to experience powerful stressors in their day-to-day lives, often living with little or nothing in the way of supportive factors. There will still be the pressures of finding employment and keeping a job; they will frequently continue to experience conflicts with

family and peers. They will still be faced with a barrage of increasingly sophisticated commercial images exhorting the "rewards" of ever greater material acquisition in an increasingly polarized society. Despite the promise of improved treatment modalities for anxiety, the pace of development of business models and practices may well have serious long-term consequences for wider society in terms of being able to effectively manage many anxiety-related mental health issues.

1. 7 An Acceptance-Based Model of SAD (Herbert & Cardaciotto, 2005)

The following section will examine in some detail an alternative model of SAD/PSA particularly with regard to acceptance based model/strategies, as these approaches have recently attracted great attention and has been shown to be effective in the treatment of a wide range of psychological difficulties including various anxiety disorders (Forman, Harbart, Moitra, Yeomans, & Geller, 2007). Herbert & Cardaciotto (2005) proposed a model of SAD (see figure-4 below) based on avoidance of social situations.

This model expanded on earlier cognitive approaches (Clark & Wells, 1995 and Rape & Heimberg, 1997) in an attempt to suggest additional theoretical mechanisms and address recognised limitations in Cognitive Behavioural Therapy (CBT), such as (Beck et al., 1985).

Herbert & Cardaciotto (2005) who had argued that some individuals have a predisposition to social anxiety which can have a genetic and/or learned component. According to Herbert & Cardaciotto (2005), when individuals with SAD encounter feared social situations, they experience physiological reactions and unhelpful thoughts relating to social evaluation. Following on from the cognitive approach, they also argue that when the anxiety-related thoughts and feelings together with bodily sensations are activated, they will in turn elicit

resource-intensive internal attentional processes and awareness, which then leads to a decrease in awareness of accurate or appropriate external cues. However, Herbert & Cardaciotto (2005)

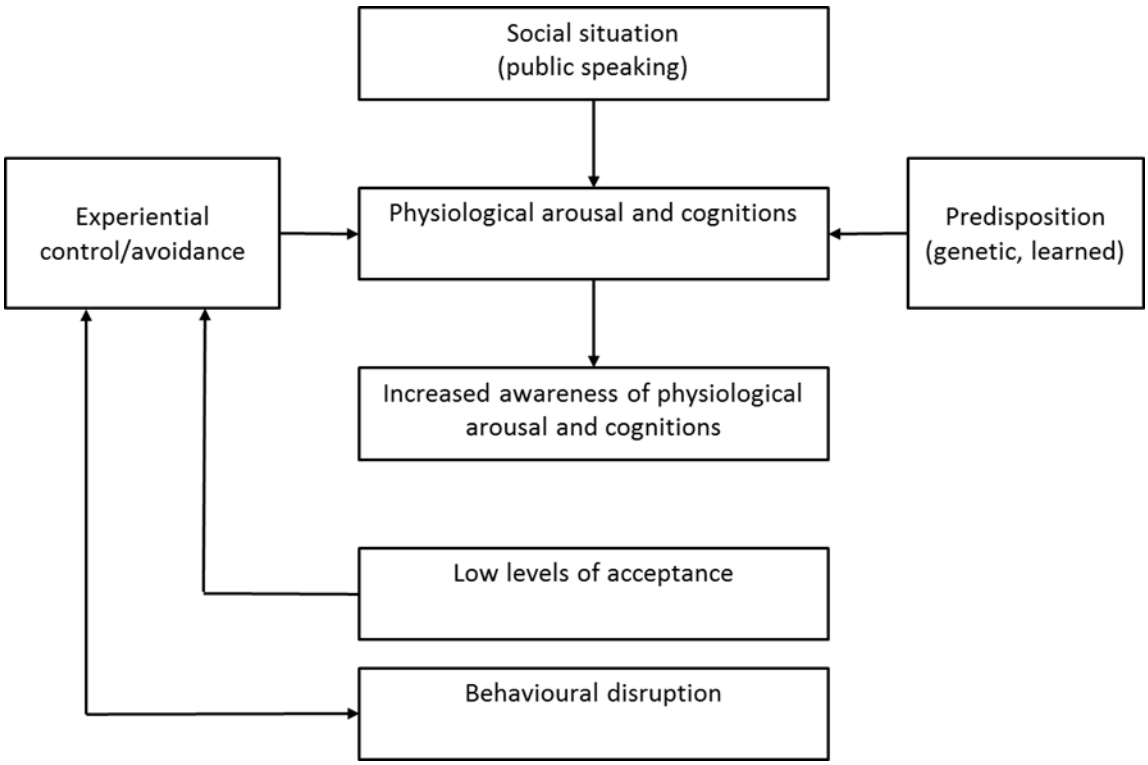


Figure-4. Acceptance-Based Model after Herbert & Cardaciotto, 2005.

expanded upon the cognitive approaches (Rapee & Heimberg 1997; Clark & Wells, 1995) arguing that problems occur, not from the internal or the external experiences themselves, but from emotional and behavioural avoidance alongside low levels of acceptance of such experiences. For example, when individuals susceptible to PSA are asked to provide a presentation, they typically experience rapid and intense physiological arousal such as blushing together with negative thoughts relating to self-beliefs and beliefs about how others see them. This leads to automatically engaging (defensively) in a variety of control strategies

intended to reduce the frequency of the thoughts, feelings and sensations, to ease their anxiety and distress. They hope by doing this to present and maintain an outwardly relaxed visage to the people around them (Wells, 2007).

Conversely, control and avoidance-based strategies typically backfire, by hindering the ability to fully focus on the situation at hand which then establishes a vicious circle of unwanted increased arousal (blushing/sweating/heat palpitation) and a heightened sense of self-attention (Abramowitz et al., 2001). This gives rise to further efforts at maintaining experiential control, including escape behaviours (such as avoiding eye-contact) due to heightened internal focus and increased self-consciousness (Wells, 2007).

Herbert & Cardaciotto (2005) postulated that interventions to treat SAD (by extension, PSA) should target increasing the level of non-judgmental, self-acceptance of one's experience. Acceptance is defined by Hayes et al (2004) as 'taking a stance of non-judgemental awareness and actively embracing the experience of thoughts, feelings and bodily sensations as they occur' (Hayes et al., 2004, p.7). This means that individuals should try to accept their thoughts and feelings as they are and do not make any effort to change these processes.

Herbert & Cardaciotto (2005) argued that adaptation of self-acceptance helps individuals to normalise and embrace fully their experience without defence or judgement, that they should simply notice any cognitive and physiological arousal without actively attempting to control or avoid experiencing it. This accepting attitude in turn may help them to reduce fear of negative evaluation and perceived social stigma (Yuen, Herbert, & Forman, 2010).

By replacing reliance upon control and avoidance strategies with a more accepting approach, individuals can devote more of themselves to the external task at hand. The acceptance-based model contrasts with traditional cognitive approaches (Beck et al., 1985)

which have aimed control-based interventions at directly disputing and changing negative thoughts associated with social situations. A more accepting approach requires a lower cognitive burden than the use of controlling strategies; the latter which some individuals may find difficult or even impossible to implement with any degree of success in real social situations.

There is a growing body of research in support of the acceptance-based model which has explored the relationship between social anxiety and adaptation of control strategies. These include thought-suppression and avoidance together with their associated negative effects. Control strategies such as thought-suppression have been found to be counterproductive and associated with increased anxiety (Wegner & Zanakos, 1994; Hayes, Strosahl, & Wilson, 1999; Hayes, Wilson, Gifford, Folette, & Shrosahl, 1996; Koster, Rassin, Crombez & Naring, 2000; Longmore & Worrell, 2007; Hayes, Villatte, Levin, & Hildebrandt, 2011).

By focusing attention on dealing with the physiological arousal (fight or flight response) these individuals have been found to experience intensified anxiety arising from the negative aspects of the experience (Hayes et al., 2011).

Forman et al, (2007) investigated an RCT for the comparative effectiveness of an acceptance-based protocol which included cognitive defusion and experiential acceptance, against a control-based protocol that included cognitive-restructuring and distraction for coping with food cravings. Participants were given transparent boxes of chocolates and instructed to keep the chocolates nearby but to abstain from eating them for two days. Both strategies were showed to be effective in maintaining abstinence however, the acceptance-based protocol was associated with better outcomes among those reporting the highest

susceptibility to the presence of food (Forman, Hoffman, McGrath, Herbert, Brandsma, & Lowe, 2007).

In another study, Eifert & Heffner (2003) conducted a research with undergraduates to examine the effects of suppression versus acceptance strategies for anxiety and panic-related disorders. In this study participants were assigned to three groups: acceptance, suppression and no-instruction group as a control group. Participants either learn to accept their unwanted anxiety-related experiences by mindful observation training or to practice control and suppression techniques using diagrammatic breathing. Participants using the acceptance approach reported less anxiety, less catastrophic thoughts and less avoidance behaviour than the suppression or no-instruction group. The latter was measured by drop-out rates and latency. This study also provided support for use of acceptance-based strategies in attenuating anxious or panic-related responding.

The aforementioned research literature suggest that suppression and control strategies may not be effective for reducing anxiety. Additionally, they tend to maintain the avoidant behaviour patterns and intensify distressing unwanted internal experiences, including thoughts, feelings and bodily sensation (Orsillo, Roemer, Block-Lerner, LeJeune, & Herbert, 2005). This also leads to potentially costly life-restrictions, for example situational avoidance which may result in missed opportunities for career development (NICE, 2013).

As a different strategy acceptance of unwanted internal experiences instead of active thought suppression can be effective in reducing the negative impact of unwanted internal experiences (Hayes, et al., 1999; Eifert & Heffner, 2003; Tull, Jakupcak, & Roemer, 2010).

One prospective therapeutic approach which highlights the importance of experiential acceptance is Acceptance & Commitment Therapy (ACT) developed by Steven Hayes and

colleagues (Hayes et al., 1999). Their approach will be discussed at length in detail within the next section.

1. 8 Summary of Social Anxiety Models

The above section described the current understanding from a psychological perspective of social anxiety. It introduced number of influential models of social anxiety together with the theory and research that examined their potential in the context of their application to further investigation, understanding and amelioration of SAD and by extension PSA. This is intended to inform and guide the development of a new cost-effective and robust treatment modality that will have the potential to reach a far wider group of individuals than otherwise previously possible.

A number of core aspects to the experience of social anxiety which are common across cognitive and behavioural models have been identified as follows (based on research and theory):

(i) Social situations activate assumptions, negative self-beliefs concerning potential performance failure and the implication of showing anxiety responses.

(ii) Unhelpful appraisals leads to perception of social danger which activates inappropriate anticipatory over-preparation and post-event rumination.

(iii) Individuals with SAD are said to be hyper-sensitive to signals from other people regarding personal acceptability and social performance. They also have critical evaluation expectancies meaning that they expect others to be overwhelmingly critical in performance-appraisal. Over-generalization and projection of an individual's own self-critical evaluation tendencies based on their past experiences/schemas has been suggested as a contributory factor.

(iv) Socially anxious individuals under a perceived social threat experience encounter self-discrepancies, typically an under-estimation of their own abilities relative to their self-perception and false assumptions regarding others` expectations of performance standards and outcomes.

(v) Negative or biased appraisals of social danger elicit physiological, cognitive, affective and behavioural responses leading to inappropriate self-focus and increasing neglect of the task at hand.

(vi) Heightened self-attention will place an unsustainable cognitive burden impacting upon any ability to respond appropriately to external cues and impairing social performance.

(vii) Social anxiety increases the bias towards detecting perceived negative audience responses such as yawning, staring and frowning whilst denying more positive audience responses such as affirmative nodding, appropriate smiling and listening intently.

(viii) Employing safety-behaviours including over-rehearsing and avoidance strategies which are considered to be significant contributory factors in maintaining and prolonging social anxiety long after the event.

(ix) Individuals with SAD are thought to have overly-high standards regarding appearance and performance in social situations. They create a mental image of themselves based on their negative self-beliefs and beliefs about how others see them. They compare this image negatively relative to images of others.

(x) Cognitive-behavioural interventions for treatment of SAD are based on the theories reviewed above. They apply cognitive-structuring to modify cognitive processes and content as well as decreasing avoidant behaviours in order to break the vicious cycle involved in maintaining social anxiety disorder. However

recent developments generating from research and literature highlights some weaknesses within the CBT approach. This has given rise to the development of a range of interventions including acceptance and mindfulness based therapies.

(xi) The Acceptance-based model of SAD postulates that active avoidance of thoughts, feelings and low levels of acceptance of those experiences leads to a promotion of anxiety. Greater self-awareness of such internal events cultivates acceptance, reduces avoidance and frees internal resources for increased resilience to distress.

The following section examines current influential treatment modalities. The discussion will also focus upon a relatively new modality that does not introduce an excessive cognitive burden (such as incurred by challenging any negative thoughts) during real social situations. The development of this novel acceptance-based approach (in contrast to control and suppression based strategies) is at the heart of the subject, being the core intervention of interest within this thesis. It has been inspired by the relatively new treatment modality of ACT and this modality in particular will be discussed at some length to demonstrate the basis, foundation and rationale for this current study.

1. 9 Traditional Psychological Treatments

In the previous section, a number of cognitive models were reviewed to explain the origins and pervasiveness of social anxiety. The most common psychological theories that underpin treatment have been based upon several cognitive-behavioural approaches including cognitive therapy (Beck, Emery, & Greenberg, 1985), exposure therapy models (Emmelkamp et al., 1985) and social deficit models (Herbert, Gaudiano, Rheingold, Myers, Dalrymple, & Nolan 2005).

There is sparse evidence of the application of some of the other models of psychotherapy including interpersonal psychodynamic and supportive psychotherapy. Thus there has been little follow-up research examining such approaches. This section therefore will primarily focus on more commonly researched psychological interventions for example Cognitive Behavioural Therapies (CBT) including exposure, social skills training (NICE, 2013; Norcross, Hedges, & Castle, 2002) and Acceptance & Commitment Therapy (ACT).

1.9.1 Cognitive Behavioural Therapy

The application of Cognitive Behavioural Therapies (CBT) in the treatment of social anxiety problems have been extensively researched. CBT to date has been the most widely utilised and studied treatment program for anxiety disorders within mainstream clinical practice (Herbert et al., 2005; Norcross, Hedges, & Castle, 2002; Andersson, Carlbring, & Furmark, 2012; NICE, 2013).

CBT includes the following therapeutic strategies: cognitive restructuring that aims to help clients (i) by altering the cognitive content through identifying the negative cognitive processes derived from maladaptive beliefs and assumptions; evaluating their empirical accuracy; deriving rational alternative thoughts and to challenge unhelpful beliefs to realign the client's thinking with reality; (ii) by direct or imaginal therapeutic exposure, which aims to modify safety behaviours and break avoidance via exposure of the client to anxiety-provoking situations in order to provide them with the opportunity to test the validity of their unhelpful cognitions and to enable them to hone their new cognitive restructuring skills; (iii) by progressive relaxation training, which is designed to help the client to manage aversive physiological responses; and (iv) through social skills training, which is designed

to help the client to learn more skilful social responding and thus enhance their personal efficacy in social-interpersonal relationships. Here, the aim of CBT is to reduce anxiety through disputing negative thoughts and structured participation in exposure exercises.

Cognitive behavioural group therapy (CBGT) has recently become one of the most studied and empirically supported treatment modality for social anxiety (Dalrymple & Herbert, 2007; Butler, Chapman, Forman, & Beck, 2006). CBGT was developed by Heimberg & Becker in 2002, based upon the cognitive model proposed by Beck et al, (1985) for anxiety disorders. CBGT employs cognitive restructuring which help clients to identify, challenge and modify the distressing cognitive and behavioural processes. Two key techniques are employed: (i) cognitive restructuring and (ii) exposure to feared situations (both in the group session and in the natural environment).The combination of these two techniques appears to provide individuals with the opportunity to re-evaluate their assumptions including mental representations of self and to gather more realistic information that may offer a viable and robust alternative to negative cognitions and predictions about self and others in social situations. In this way, the individual can gain the required confidence to displace their avoidance and safety behaviours, and habituate to feared and avoided situations via exposure (Heimberg et al., 1995). The group format of CBGT may also increase the potential for modifying the mental representations via offering additional sources of positive feedback about one's performance within a safe social setting that simulates a public arena. CBGT has been shown to be effective for social anxiety, studies conducted by Herbert et al (2005) and Chen et al (2007) have demonstrated its effectiveness.

1.9.2 Exposure Therapy

Exposure Therapy (ET) is a form of behavioural therapy which targets avoidant behaviour in the perpetuation of social anxiety and fear of public speaking. Avoidant behaviour is motivated by a perceived fear of punishment by others. The perceived and anticipated punishment such as the prediction of rejection, humiliation and isolation, remains disconfirmed or not tested. In support of ET, a Hope et al (1995a) study also found that the exposure therapy alone was as effective as cognitive restructuring, suggesting that modifying negative cognitions (as in CBT) may not be necessary to engage in exposure (Hope, Hiemberg, & Bruch, 1995).

Several meta-analyses focussing specifically on fear of public speaking treatments found exposure to be effective in the treatment of both PSA and as well SAD (Federoff & Taylor, 2001; Taylor, 1996).

ET can be conducted in vivo or in imagery including virtual reality via multimedia/computer (e.g. Yuen et al., 2010). A unique feature of ET is the emphasis placed on the systematic exposure to feared situations. In this therapy the therapist and client collaboratively develop a hierarchy plan from the least to the most the feared situations. Clients are encouraged to systematically confront their fears in a graded manner until habituation occurs. For example, initially using role play a client might be asked to introduce herself to someone for five minutes; the next stage may involve the individual initiating a conversation in a classroom setting and which lasts perhaps ten minutes. Through this graded exposure process, the therapy aims to allow clients to test out the accuracy of their beliefs via behavioural experiments and to disconfirm unrealistic beliefs (Hope et al., 1995).

There have been problems with the use of ET alone where for example tasks might be too brief and infrequent such that there is no appreciable reduction in the level or impact of the anxiety (Heimberg, Dodge, Hope, Kennedy, Zollo, & Becker, 1990). Furthermore, clients may refuse self-exposure or drop out early (Heimberg et al., 1990) due to the perceived stress of such exercises. Reasons for treatment failures include: depressed mood; avoidant personality; intolerance of emotion and marked avoidance behaviour (Wells, 2007) As mentioned elsewhere, there may also be on-going stressors within the individual's home, social and/or work life that cannot be easily managed and which contribute to loss of confidence in ET and withdrawing from treatment.

1.9.3 Social Skills Training

Social Skills Training (SST) is another form of behavioural therapy which utilises a social deficit model. Here, it has been argued that individuals with SAD experience difficulties with social performance such as poorer speaking performances (Hofmann & Otto, 2008) that may cause anxiety and fear in social situations (Herbert, 1993).

However, critics argue that most of the individuals with social anxiety possess adequate social skills, but that these skills are inhibited or under-used when it comes to applying them in social situations. This may be due to excessive anxiety or to having biased perceptions about one's abilities, as opposed to having an actual skills deficit (Herbert, 1993; Rapee & Lim, 1992). But it has to be borne in mind the possibility that the same critics might lack a real understanding of the impacts of societal, family and peer pressure stressors in marginalized communities.

Despite these debates, SST has been shown to be an effective treatment for social anxiety difficulties (Federoff & Taylor, 2001; Taylor, 1996). This therapy entails identification of

aspects of a problematic social performance for example when making a presentation. Following this, the therapist will show appropriate ways in which to perform the presentation and will rehearse this with the clients through role-playing and modelling to improve social skills and facilitate exposure to feared situations.

Although SST has been shown to be an effective when incorporated into CBT or exposure therapy for social anxiety problems including public speaking anxiety, it is not used as a sole treatment due to a lack of research demonstrating its efficacy. (Rodebaugh, Haloway, & Heimberg, 2004).

1. 10 Usefulness of Current Cognitive Behavioural Therapies

Studies examining the efficacy of cognitive behavioural therapies for social anxiety have revealed mixed results. CBT has produced impressive outcomes for many mental health problems including SAD. It has been delivered in different guises including guided and non-guided self-help, group and individual formats to increase access and dissemination (Heimberg et al., 1998; Hope et al, 1995). UK economic factors underlie limitations in the provision of frontline services due to training and supervision costs of healthcare professionals, thus briefer therapy formats using more cost-effective delivery variations such as group based interventions and self-help have gained popularity. With regard to format comparisons, a meta-analysis conducted by Gould et al (1997) had found no difference in the effectiveness between group and individual delivery formats of CBT. Supported or internet-based self-help for social anxiety has been found to be more effective than unsupported/no treatment (Andersson, Carlbring, & Furmark 2012; NICE, 2013).

Furmark and colleagues (2009) compared guided and non-guided self-help CBT with a wait-list and found that both non-guided and guided formats can produce enduring effects (one

year follow-up) for people with social anxiety. However Carlbring et al (2009) argued that the self-help format can be challenging for some clients who find it difficult to motivate themselves to engage in feared situations (Carlbring, Nordgren, Furmark, & Anderson, 2009).

Although CBT has been shown to be effective for some individuals' treatment of social anxiety, results from a small number of studies have reported that existing CBT treatments are not effective for every individual who experiences SAD and PSA (Dalrymple & Herbert, 2007; England et al., 2012). Dalrymple & Herbert (2009) argued that many clients either displayed residual symptoms after the treatment stopped or did not respond to traditional CBT. (Dalrymple & Herbert, 2009). For example a study conducted by Hope et al (1995) investigated the efficacy of CBT for SAD and found that the only 18% of the participants with SAD appeared to respond to CBT; the results from this study were rated by independent evaluators.

CBT has been criticised for placing emphasis on control and management-oriented strategies that includes focusing on symptoms reduction and employing distraction techniques together with suppression. As mentioned elsewhere this has been noted to be counter-productive and highly correlated with increased suffering (Abramowitz et al, 2001). This was suggested to be typically due to a paradoxical increase in the undesired internal experience (Eifert & Forsyth 2007). This added to the debate, as some studies had found behavioural elements of CBT to be more effective, yet the same studies had also suggested that other components such as cognitive restructuring were actually superfluous, not adding any significant value to the effectiveness of treatment (Longmore & Worrell, 2007; Hayes, 2004).

CBT was also criticised for adopting a problem-focussed approach, which tends to deal with distress by challenging dysfunctional cognitions and emotions (Hayes et al., 2004). The constant striving to challenge and modify the unwanted thought process was said to be placing excessive focus on content of the cognition which in turn maintains the rumination element, intensifying the struggle to rid oneself of unwanted cognitive and/or emotional materials (Eifert & Forsyth, 2005; Roemer & Orsillo, 2009). This suggests that cognitive structuring in traditional CBT may be considered counter-productive specifically in two ways, by (i) encouraging suppression of "faulty thoughts " which has the effect of making them occur more often; and (ii) by facilitating a diminished sense of mastery (Longmore & Worrell, 2007).

The increased cognitive burden from the effort of additional focusing on symptom reduction, the elimination of "faulty" thoughts and associated bodily reactions, may create an untenable cycle of increasing suppression by intensifying desire to suppress the "faulty" thought. In support of this criticism, a number of studies have shown that both conscious and unconscious thought-suppression can produce the opposite of the desired effect (avoidance) to a degree that facilitates the return or intensification of the undesired thought (Wegner & Smart, 1997; Abramowitz et al., 2001; Wegner & Zanakos, 1994). In turn, any return of undesired materials may further fuel the feeling of a lack of control. Given that the evidence suggesting many of the SAD clients had experienced low perceived emotional control or mastery, this would indeed create further adversity (Leung & Heimberg, 1996).

It has also been argued that conventional CBT adapts a reductionist approach that focuses solely on the analysis of the 'dysfunctional' behaviour, rather than placing common behavioural and cognitive responses within a historical and contextual position (Eifert & Forsyth, 2005; Ruiz, 2010). That is, CBT attributes psychological problems that emanate

from pessimist thought patterns only to elements within the individual. It disregards the outer-world, multi-factorial nature of anxiety and distress such as the role of language, social dynamics and discrete stressor events which might strongly influence an individual's capability and manner of response when dealing with problematic issues. The reductionist approach firmly aligns traditional CBT within the medical model framework which ascribes negative/dysfunctional cognitions and emotions as abnormal and locates the psychological problems within the person rather than looking at the larger picture (Szasz, 2010).

This review has shown there is a need to develop alternative ways of working therapeutically with individuals experiencing SAD and by extension PSA. The very nature of modern life means that individuals' social, academic and working lives are increasingly stressful, requiring not only more effective therapies but also more flexible and more frequent access to therapeutic input. In light of the new societal challenges, it should be of concern that the literature review identified that individuals with SAD/PSA did not respond to a mainstream CBT approach and continued presenting residual symptoms after therapy. In the search for more effective therapeutic approaches to managing PSA, Acceptance & Commitment Therapy has been selected as a promising candidate. To date there is much interest in the usefulness of ACT for SAD specifically, but studies to date for its application in the management of PSA have been extremely limited**.**

Shortcomings of CBT-based therapy for SAD/PSA are cited within the literature review despite conventional CBT-based treatments having been previously empirically supported for treatment of SAD and PSA. The results from a number of recent studies, for example Dalrymple & Herbert (2007) have reported that existing CBT treatments are not effective for every individual. Factors that might account for this may include poor quality of delivery

due to inadequate training or rushed delivery due to financial/time constraints; also the aforementioned family/community stressors may overwhelm the individual. Many researchers, including Eifert & Forsyth (2005) have also suggested that traditional cognitive restructuring, the viewing of psychological difficulties as the result of maladaptive thought processes is not an effective approach in the treatment of social anxiety.

One potential avenue to the desired improvement of therapeutic outcomes in an increasingly challenging world, is offered by Acceptance & Commitment therapy (ACT). This is one of the evidence-based trans-diagnostic behavioural therapies that views human distress and suffering as normal and as being a perfectly natural response to difficult life situations and experiences. ACT employs acceptance and mindfulness, it values clarification and committed action in order to enhance traditional behavioural interventions (Hayes, Strosahl & Wilson, 2012). Acceptance is defined as actively engaging in the process of experiencing all private events fully and without attempting to change these experiences (Hayes et al., 1999). Commitment is the process of choosing behaviours which are consistent with chosen values in the presence of undesired private experiences that have historically functioned as conditioned stimuli for unhelpful thoughts and behaviours (Harris, 2009). In recent years, ACT has gathered increasing interest in relation to the resolution of anxiety difficulties. ACT has a growing evidence-base in terms of its efficacy in improving psychological outcomes and also for treatment adherence in respect of various psychological conditions (Hayes et al., 2006; Ost, 2008; Ruiz, 2010; Ruiz, 2012). ACT appears to be particularly relevant to anxiety management because its approach specifically targets ineffective and unhelpful control strategies such as avoidance.

Whilst having some similarity to the cognitive behavioural models discussed above, the ACT approach also recognises the important role of the cognitions and other private events

playing out which have a significant role in the development and maintenance of psychological difficulties. However, in contrast to a focus on recognition of the negative thought content and trying to change it as with traditional CBT, the ACT model attempts to change an individual's relationship with their cognition and the context in which such cognitions are experienced (Hayes et al., 1999). The next section will review ACT theory and research findings, to suggest how this might be applied to practice in relation to PSA.

1. 11 Introduction to ACT

ACT is often described as a third wave of the CBT approach as developed by Hayes and colleagues (Hayes et al., 1999). ACT continues to gain recognition as an effective therapy for a wide range of psychological difficulties. The evidence emerging from current research suggests that therapeutic approaches which emphasize active (resource intensive) thought management through cognitive restructuring activities are ineffective (see Dalrymple & Herbert, 2007; Hope, Heimberg & Bruch, 1995; Longmore & Worrell, 2007), that they may have a paradoxical effect (Abramowitz et al., 2001), exacerbating the very events that the person was trying to control and avoid. In order to better understand and overcome this effect, an increasing number of researchers have begun to look at this problem in a new way, with a change of emphasis which highlights the importance of acceptance and mindfulness strategies when dealing with difficult thoughts and feelings. Mindfulness is defined as an ability to be in the present moment with "full awareness and openness to distressing thoughts and feelings" (Harris, 2009 p.12). It is the mindfulness and acceptance components of ACT that endow it and other similar approaches with a distinctively different quality and thus the "third-wave" label. ACT has also been incorporated as a mediation technique into other CBT approaches, for example Dialectical Behavioural Therapy (Linehan & Kehrer, 1993).

Before examining ACT and its relevance to public speaking anxiety, the next session will briefly examine the foundations of mindfulness-based therapies.

1.11.1 Mindfulness and Acceptance

The concept of mindfulness has roots in Buddhist and other contemplative spiritual traditions (Kabat-Zinn, 1994). It is seen as an actively cultivated process where conscious attention and awareness are focused on the present moment. Mindfulness was defined as a full awareness that arises through "paying attention in a particular way: on purpose, in the present moment, and non-judgmentally" (Kabat-Zinn, 1994, p.4; Baer, 2003; Baer, 2006).

Mindfulness has become increasingly popular in Western psychology, likely due to its simplicity in terms of teaching and practicing together with its strength to act as a counterpoint to rumination about the past and/or anxieties about the future. Interest in mindfulness as a therapeutic approach began to emerge during the 1960s (Vreeswijk, Broersen, & Schrurink, 2014). Throughout the 1980s and the 1990s, mindfulness was increasingly applied to a broad range of difficulties. Jon Kabat Zinn (1990) applied meditation in a clinical setting with clients who were experiencing pain and psychosomatic symptoms. This program was called "Mindfulness Based Stress Reduction" (MBST) which included mindfulness training consisting of three-hour sessions lasting eight weeks (Cited in Vreeswijk et al., 2014, p.13). These sessions combined meditation and yoga techniques alongside encouraging participants to become more aware of the present moment and to develop different relationship with their own thoughts, feelings, and body sensations. Research has also suggested that MBSR may be an effective intervention for managing physical ailments such as, fibromyalgia (Kaplan, Goldberg, & Galvin-Nadeau, 1993) chronic pain (Kabat-Zinn, Lipworth, Sellers, Brew & Burney, 1985).

Teasdale, Segal and Williams (1995) conducted pioneering work based on MBST (Kabat Zinn, 1990) and developed Mindfulness Based Cognitive Behavioural Therapy (MBCT). Teasdale and his colleagues were motivated by the lack of successful therapy programs in preventing depressive relapse. Their MBCT program integrated mindfulness meditation and traditional cognitive behavioural therapy techniques designed to help clients with recurrent depression. MBCT has been found to be effective in reducing the rates of depression relapse by approximately half, compared with a control group which received treatment as usual (Ma & Teasdale, 2004).

Bishop et al (2004) proposed a framework to explain the process of mindfulness which included two primary components (i) attention regulation to the present moment (ii) developing an attitude of non-judgmental acceptance toward one's experiences. These are considered the main tenets of mindfulness which deemed to be potentially effective for amelioration of unhelpful cognitive processes such as rumination and worry, which for susceptible individuals can lead to psychological distress and inflexibility (Vreeswijk et al., 2014; Bishop, Lau, Shapiro, Carlson, Anderson, & Carmody, Devins, 2004).

As discussed above, mindfulness-based interventions may be both practical and effective for reducing stress and depression in both clinical and community samples (Shapiro, Schwartz, & Bonner, 1998).

Research has demonstrated that mindfulness-based interventions are effective as a supplement to existing treatment methods for a wide of difficulties including substance misuse, (Witkiewitz, Marlatt, & Walker, 2005); affective disorders (Linehan & Kehrer, 1993).

Research has suggested that mindfulness can lead to beneficial functional and structural changes within specific of the brain such as the insula, prefrontal cortex and limbic system. This is believed to enhance cognitive and emotional processing (Davidson & Lutz, 2007; Baer, 2010).

The aforementioned studies have provided support for mindfulness to counter-balance worry and anxiety. ACT is an acceptance and mindfulness-based approach which applies mindfulness in the following manner, involving four key intentions; (i) acceptance of experience; (ii) defusing from the literal meaning of the thoughts; (iii) working towards development of a transcendent sense of self and (iv) continuous contact with the present moment (Fletcher & Hayes, 2005). These processes aim to provide a context in which the person experiences their private events in the present moment and is able to observe them dispassionately without treating them as reality. However, ACT emerges from a behavioural tradition, placing greater emphasis on the use of commitment and behavioural change strategies to promote psychological flexibility (Hayes, et al., 2006). In relation to PSA, ACT aims to reduce PSA-related avoidant behaviours and also emotional reactivity to negative self-beliefs or self-referential processes (Hayes, 2008; Goldin & Gross 2010).

The aforementioned studies are unfortunately subject to several methodological issues including having small sample sizes, a lack of either control group or random assignment and a lack of standard measures (Germer, Siegel, & Fulton 2005; Park, Reilly- Spong & Gross, 2013). However, as research evidence in this area grows, there is a need for much more rigorous studies employing robust methodologies including the use of reliable and valid self-reported mindfulness measurements.

1.11.2 Foundations of ACT

ACT is based on Relational Frame Theory (RFT) which describes the nature of the language and cognition and how they are related to psychopathology (Hayes, 1987; Barnes-Holmes, Hayes, Barnes- Holmes, & Roche, 2001). RFT is informed by the philosophical perspective known as functional contextualism (FC). RFT is a "Post-Skinnerian" contextual behavioural theory concerning the nature of the human language, cognitions and the way in which they influence the organism in terms of cognition, emotion, and behaviour (Hayes et al., 2011). The primary assertion of RFT is that verbally mediated internal events such as cognitions, emotions and memories influence behaviour through the context in which they occur. According to RFT, humans find themselves acting according to a number of unhelpful verbal rules. Human behaviour that is initiated and regulated by these symbolically derived verbal rules is known as rule governed behaviour (Strosahl, Robinson, & Gustavsson, 2012). Language encourages rule-governed patterns of behaviour. The nature of symbolic behaviour, or the functions of symbols or rules are altered because they enter into a relational frame with other stimuli. For example, "fear" and the thought "I am afraid" can be considered as a trigger for "running away." If a child is told that snakes are something to be afraid of, dangerous, quick and unpredictable then this rule essentially specifies a set of conditions in which the child is deemed at risk (encountering a snake) and describes the specific behaviour that is to be employed (running away). If the child does indeed encounter a snake then the rule probably will kick in and the child will run away. Therefore the rule "snakes are dangerous" will govern the behaviour even though it may well never be directly tested in the real world. These childhood verbal rules not only regulate the behaviour but can also generate unhelpful cognition and emotional states in later life. For example if snakes (or more likely spiders in the UK) are considered dangerous, swift and also unpredictable then if as an adult that person has a sudden unexpected experience akin to

coming across a snake or spider unexpectedly and that event catches them unawares, the "snake rule" kicks in triggering a flight response.

Many of these verbal rules or relational framing have been shaped by individuals` social environment and have been reinforced by parents, peers, school, and society at large and subsequently perpetuated over the years (Wells, 2007). As a tool to deal with actual physically dangerous situations, the fight or flight response is desirable. However, in relation to public speaking anxiety, such tools when allied with perhaps over-protective parenting during childhood can be problematic in subsequent adulthood. Any previous learned history, or a particular stimulus for example being criticised by a teacher, can evoke unwanted private events (thoughts and feelings/sensations) leading to psychological distress. ACT theory suggests that such distress predominantly stems from psychological inflexibility fostered by fusion/entanglement with the content of internal experiences that dominates an individual`s thinking, behaviour and reactions to the world around them (Hayes et al., 1999). That is, even in adulthood, verbal rules learned in childhood, are taken literally as an objective truth and construed as events that needed to be automatically avoided, for example the generalization that "If I feel fearful then really, there is something to fear" rather than considering it only being true in a particular context.

Within ACT, psychological difficulties are assumed to be entirely functionally based and contextually determined. Language processes are considered to be one of the important contextual factors leading to human suffering (Hayes, 2004).

Hayes (2004) postulated that language provides people with an ability to relate between events based on their arbitrary or non-arbitrary features. With this ability people are able to derive relations and make associations between events. From an RFT perspective an

emotion is a relational network involves derived relational responses for example, a socially anxious person when exposed to the phrase "public speaking" may experience floating memories, thoughts and images such that PSA can be considered "equivalent" to fear or perceived as dangerous which can create a "causal relationship between stimuli" (fear) and "equivalence of stimuli" (public speaking) and "hierarchical relationship between stimuli" where "public speaking" is considered as part of something larger, in this case; giving a speech in a formal classroom setting before a number of people (Blackledge, 2003, p. 423). Making derived relational responses between stimuli (fear and public speaking) results in transformation of stimulus functions for all the stimulus involved including fear, sweating and rapid heart rate and unhelpful thoughts such as "I am incompetent, I am hopeless, I must not show my anxiety" as if danger is real and really "here and now." These types of experience will eventually evoke thoughts of panic about possible exposure to that anxiety provoking situation. Even if public speaking is not to be undertaken, simply hearing the mere phrase "public speaking" can have the same or similar stimulus as a real public speaking event might do because that stimulus reminds them of something they dislike or find aversive. Furthermore, the aforementioned derived relations (public speaking equals danger and fear) cascade out and start to become all inclusive, pervasive and absolute which creates inflexibility and problematic fusion (Hayes, 2004).

This cognitive fusion/entanglement with distressing thoughts and feelings inevitably will dominate the person's behaviour in a limiting and unhelpful way because over time they produce behavioural and psychological rigidity leading to a loss of contact with important values. For example a person may foster experiential avoidance to ease their public speaking anxiety, but by avoiding a presentation may lead to missing out on a rewarding experience or failure to taking up an interesting opportunity.

These behaviours that attempt to reduce or eliminate the presence of aversive thoughts, feelings, and bodily sensations is called experiential avoidance (EA). Hayes et al (1996) defined EA as "unwillingness to remain in full contact with present moment and inner experiences that are occurring"(Hayes, Wilson, Gifford, Follette, & Strosahl, 1996, p.1154). Examples of EA could include diverse activities such as substance abuse; avoiding situations, people or relationships; procrastinating; over-sleeping and over-eating. Hayes et al (1996) suggested that such evasive and control strategies increase suffering by developing and maintaining many forms of psychopathology (Hayes, 2004, Lillis & Hayes, 2007). From an ACT perspective, EA is only considered problematic when it significantly interferes with the pursuit of personal held values and goals, or when it entails harmful behaviours such as illicit drug use and excessive alcohol use (Hayes, 2004).

The goal of functional contextualism is to predict and influence behaviour effectively using empirically supported principles. The ultimate aim is to help humans to create rich, full and meaningful and valued living. Within the functional analysis, ACT encourages people to increase their awareness of their own behaviour (both public and private) and to notice how it functions in the context of their life. They are invited to examine the effects of their behaviour by reflecting on issues for instance: what purpose does their behaviour serve, what are the consequences and what is it intended to achieve? Does it improve their lives or not?

Hayes et al (2006) argued that thought suppression or an attempt to modify the content of inner experiences has a paradoxical effect. That is, it is said to reinforce the relational network associated with the dysfunctional thought thus leading to excessive rumination, cognitive entanglement and unhealthy self-focus (Hayes et al., 2006; Abramowitz et al.,

2001). To counter this, ACT aims to create psychological flexibility (Hayes et al, 2006) by employing non-defensive, experiential acceptance and mindfulness strategies. The acceptance-based strategies disrupt the transformation of stimulus functions and derived relational network and encourages the client to experience their unwanted thoughts and feelings in a non-judgmental manner (Hayes et al., 2006).

There is no single prescribed approach to employing ACT; further, there is no strict set protocol or manual to follow. Therapists who employ an ACT perspective work through six inter-related core therapeutic process that are typically illustrated with the help of a hexagon-shaped diagram forming a so-called "Hexaflex" model (see figure-5 below). Individuals are encouraged to use experiential exercises provided in the ACT book by Hayes et al (2012) alongside any additional materials the therapist deems appropriate, thus creating exercises and metaphors which are related to the culture they live in. However, a therapist who employs the "Hexaflex" may not necessarily need to have the individual work on all six processes, it would depend upon the client's needs and materials (Harris, 2009; Luoma, Hayes, & Walser, 2007, Hayes, et al., 2012).

As a material resource, the Association for Contextual Behavioural Science (ACBS) is considered to be the primary ACT research and clinical base and is a good starting place. It should be noted that whilst there is at present no formal training programme for ACT, it is still essential that peer supervision is undertaken.

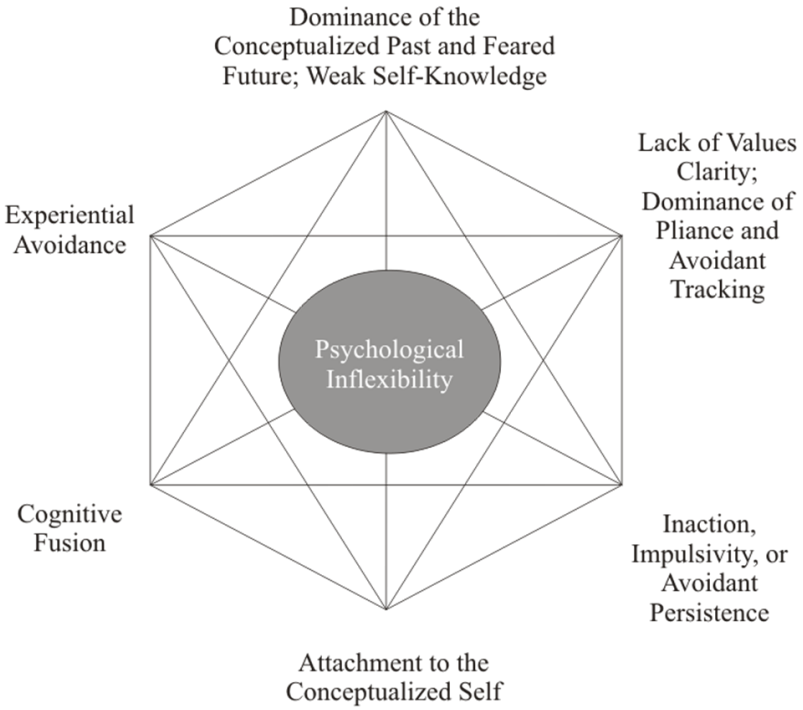


Figure 5. The ACT Hexaflex model of psychopathology, Hayes et al., (2006)

1.12 ACT Model of Psychopathology

According to the ACT model, the primary source of psychopathology is the psychological inflexibility which often involves unhelpful tendencies to avoid, suppress and entangle with distressing thoughts and emotions (Hayes et al., 1999). The ACT model identifies six corresponding processes which increases flexibility; cognitive defusion, experiential acceptance, clarity of values, being present in the moment, self-as-context, and commitment to valued action. The intervention aims to teach acceptance and mindfulness techniques in order to reduce the influence of the literal, evaluative functions of the verbal content of cognition over behaviour and increase flexible contact with the environmental contingencies that are available in the present moment, whilst enhancing the client's commitment to changing their behaviour in the service of whatever he or she truly values in life.

1.13 Destructive Normality

ACT focuses more on a trans-diagnostic conceptualisation of psychological well-being, meaning that distress and suffering are considered as a reasonable and natural learning process to the challenging situations (Hayes, 2004). This is by way of contrast to more traditional models of psychopathological diagnostic categorisation. At its core, ACT works from the assumption of destructive normality alluding that normal human psychological features such as emotions and cognition can lead to extremely dysfunctional and destructive results (Hayes et al., 1999). These dysfunctional cognitions and emotions are not deemed to be 'faulty' or 'ill health' because both positively and negatively evaluated cognitions are driven from the same everyday language processes which support essential everyday cognitive abilities such as verbal problem solving and reasoning. By implication no individual is assumed to be broken or needing to be fixed. From the ACT perspective all humans (both clients and therapists alike) share similar vulnerabilities and experience distress which lead them to lose contact with their core values and to fall into socially prescribed or constructed daily routines that do not contribute to their valued directions. Negative feelings are normal, they are not abnormal, unhealthy and to be controlled (Harris, 2009).

1.14 An ACT View of PSA in Relation to Avoidance

ACT formulates the problem of distressing anxiety in terms of psychological inflexibility, where individuals engage in activities, which produce short term relief from psychological pain such as suppression and avoidance; but conversely this prevents engagement in valued living in the longer term (Hayes, 2004). Within ACT, the presence of negative emotions is not assumed to be the causal determinants of the client's ability to engage in public speaking

tasks. Rather, any difficulties in speaking in public are presumed to stem from the human tendency to evaluate private experiences arbitrarily as 'good' or 'bad' and fuse with/or identify with the literal meaning of these evaluative labels and in turn, engage in excessive, inflexible avoidant behaviours (Eifert & Forsyth, 2005). This leads them to lose contact with their core values. Over time, the client's strategy of controlling and avoiding difficult psychological events typically produces a narrow and inflexible pattern of action and psychological inflexibility (Hayes et al., 1999). Such rigidity and inflexibility leads individuals to suppress and avoid controlling their private experiences. In the short term, attempts to control such aversive private events may have a limited usefulness. But over time they become ineffective and paradoxically will result in more of the same thoughts and emotions as initially experienced (Abramowitz et al., 2001; Hooper & McHugh 2013). For example, a person who drinks alcohol to eliminate difficulties or "to calm nerves" may also unwittingly develop an alcohol dependency leading to other difficulties such as self-neglect, risky behaviours, increasing debt and poor physical health. Efforts to eliminate and avoid internal difficulties (via distraction, suppression, behavioural avoidance, cognitive re-structuring) not only produces emotional costs by intensifying the presence of unwanted experiences but also brings significant behavioural costs where individuals` lives will be restricted or distorted by less than optimal behaviour and not lived in the proper service of their deeply held values (Hayes et al., 1999; Hooper, Stewart, Duffy, Freegard, & McHugh, 2012).

The ACT approach encourages the client to shift from entanglement with the unwanted inner experiences to orientating behaviour toward desired, chosen values even whilst in the presence of distressing experiences (Harris, 2009). It utilises acceptance and mindfulness strategies to alter the negative functional effects of inner experiences, reframing them in a

different (Acceptance based, soft and compassionate) context such that avoidance becomes less likely to be the dominant response to these private experiences. To achieve this, individuals are encouraged to accept their full range of undesirable thoughts, feelings and physical sensations rather than actively struggling with them. Individuals learn to be more open to unpleasant feelings and to take a non-judgemental, allowing attitude toward whatever emotions arise including the troublesome anxiety provoking ones (Harris, 2009). Through this practice individuals will develop an ability to mindfully turn their attention to toward a positive value based action. For example when taking part in ACT activities, clients will be encouraged to see their anxiety-related inner experiences as simple and readily changeable aspects of their perceived life rather than seeing them as objective reality. Clients are encouraged to let their experiences occur naturally within the body and to learn to notice them, to allow them to occur, to embrace and continue their chosen valued direction. This process is accomplished through the six core psychological processes mentioned above (see below, figure 6).

The next section will discuss the application of ACT to the amelioration of PSA experienced by an affected individual.

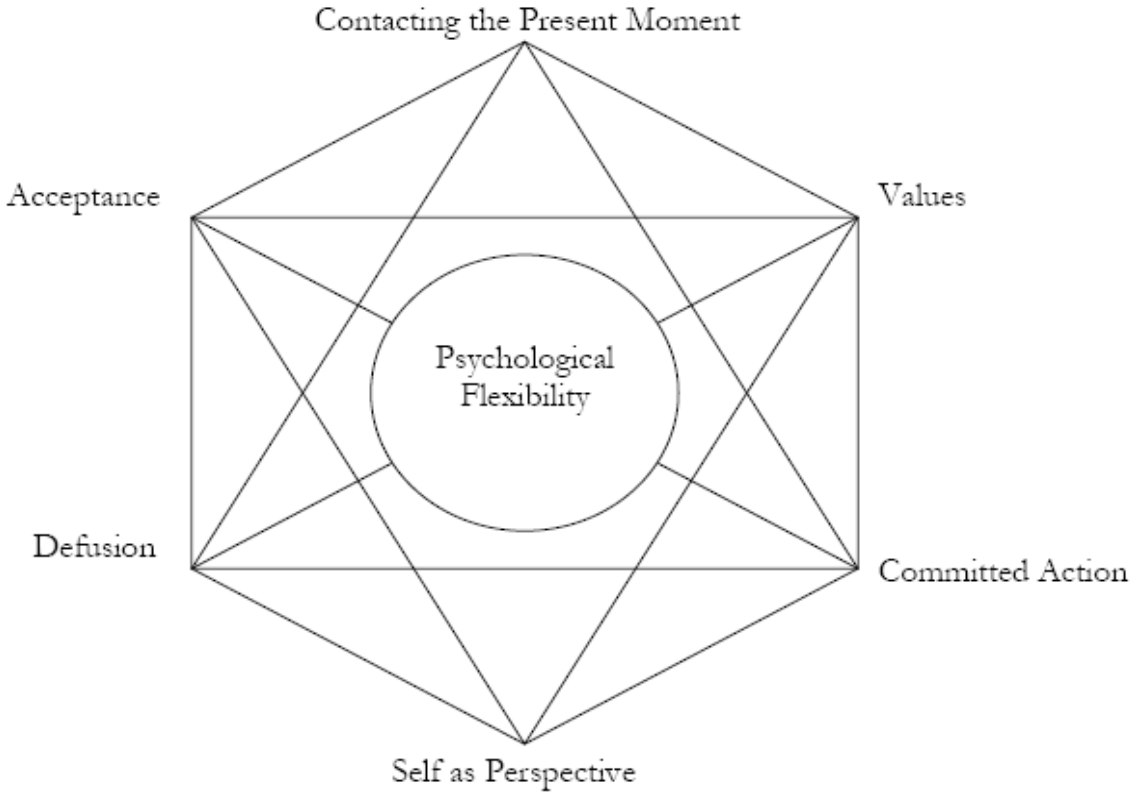


Figure 6. ACT Model (Hayes et al, 2006).

1.15 Six Core Processes of ACT and PSA Application

Given that PSA is characterised by distorted self-beliefs, attentional biases and avoidance) Wells, 2007). ACT is particularly appropriate for the population under study here due to psychological inflexibility typically seen in such an individual. PSA deficits in present moment focus, experiential acceptance, cognitive defusion, valued living/committed action and transcend self-awareness. ACT focuses on the functions of PSA in the context of the person`s life. In order to cultivate flexibility, ACT focuses changing the context in which the PSA repertoire had emerged and had become learned. As mentioned previously, ACT promotes psychological flexibility through six interrelated core processes. Hayes et al (2006) termed these processes as "acceptance", "cognitive defusion", "being present", "self as context", "values" and "committed action". A therapist employing the ACT approach

may choose to work on any one or more of those core processes by blending them together as they are activated by client material (Luoma, Hayes, & Walser, 2007). The six core processes will now be reviewed with respect to their relevance to PSA and evidence will be provided in support of their therapeutic application.

1.15.1 Acceptance

Acceptance is "an active and aware embracement of private events occasioned by one's history, without unnecessary attempts to change their frequency or form" (Hayes et al., 2006, p.7). Hayes (2006) suggests that lack of awareness and active avoidance (experiential avoidance) of thoughts and emotions are particularly destructive to psychological well-being. In line with this, a meta- analysis study conducted by Hayes et al (2006) showed that the higher levels of psychological flexibility was associated with higher quality of life and reduced experiences of psychopathology (Hayes et al, 2006).

ACT thus fosters embracement and acceptance of all aspects of private events even the negative experiences whilst undermining the dominance of emotional control and avoidance.

ACT encourages PSA clients to take a stance of non-judgmental awareness and to actively embrace their private/internal events (thoughts, memories, perceptions, emotions) without resisting, avoiding and suppressing them via experiential avoidance (Harris, 2009). Acceptance is taught as an alternative to experiential avoidance which is described as an attempt to alter the form or frequency of private events, even if this leads to engaging in undesired or unhelpful behaviours (Hayes et al., 1996, p.7). An example of experiential avoidance might be where an individual with PSA either avoids or suppresses their private events in order to reduce distress. Paradoxically, this actually increases their frequency and

intensity and narrows the individual's behavioural repertoire by forcing them make choices based on avoidance rather than upon their core values, thereby failing to engage in flexible and committed values-based action (Hooper et al., 2012).

Such experiential control/avoidance based strategies have been found to be associated with poorer quality of sleep (Schmidt, Harvey, & Van der Linden 2011); heightened pain experience (Johnson, 2008) increased anxiety and panic (Koster, Rassin, Crombez, & Naring, 2003) and emotional exhaustion (Wegner & Zanakos, 1994).

Techniques pertaining to acceptance include helping participants to focus on the present moment and inviting clients to open up to their unwanted thoughts and feelings, their urges and sensations with full awareness and non-judgementally (Harris, 2009). They are encouraged to observe and accept and let go of the worrying thoughts that previously were staying with them, noticing how they are fleeting, temporary and will dissipate naturally without effort. When individuals accept their unwanted inner experiences they may also learn that their experience is not as threatening as they feared or expected it to be (Hayes, 2004).

The concept of "willingness" is sometimes used interchangeably with 'acceptance' in ACT, since acceptance from an ACT perspective is a willingness to experience difficult thoughts and feelings in the course of behaving consistently with ones values (Harris, 2009). Acceptance or willingness is not a process of resignation or toleration of negative events because it is viewed as a choice and welcoming stance towards all inner, private experiences (Harris, 2009).

In ACT, clients are invited to examine the result of their avoidance and suppression strategies while considering their values. They would be encouraged to examine the verbal

rules first, to expend energy controlling and managing the anxiety; and to explore whether their active efforts to manage anxiety had been successful or that by following that verbal rule has brought them to closer to their valued direction in terms of relational intimacy, physical health, spirituality; or in reality, has distanced them from their valued life directions (Hayes et al., 1999) .Usually, clients can see the futility of their attempt to actively suppress their thoughts, to try and effect control over their anxiety, to try to make sense of the functionality of the human mind (Harris, 2009).

1.15.2 Cognitive Defusion

The ACT approach suggests that language-based processes and traps can promote unwanted cognitive fusion and unhelpful evaluation, thus leading to internal events which function as a psychological barrier to living in accord with chosen values (Hayes et al., 2006). Through cognitive defusion, individuals are invited to observe, let go and distance themselves from the literal quality of their thoughts, for example a public presentation equals panic, so that cognition can no longer rigidly dictate their behaviour (Hayes et al., 2006).

Cognitive defusion techniques involve altering the context in which undesirable internal experiences such as negative feelings, thoughts, sensations and urges occur; the intention being to weaken their literal/linguistic quality as opposed to attempting to change their content, forms or frequency (Hayes et al., 2006). In so doing, by defusing or de-centring from distressing functions of internal experiences, not only is the literal meaning decreased but also the automatic impact, believability or attachment to private events is reduced. In this process, ACT uses experiential exercises and metaphors to contact the self as a secure sense of oneself, which is separate from private events (Hayes, Bissett, Korn, Zettle, Rosenfarb, Cooper, & Grundt, 1999a). For example, clients are encouraged to see a

"negatively loaded" thought as a perfectly normal thought for example "I am having the thought that I am worthless." Rather than dwelling on the literal meaning "I am worthless" the client is encouraged not to label the negative thought as correct or incorrect but to simply see them as fleeting "junk thoughts" rather than being useful in achieving a more valued life. Defusion exercises are practised such as "I am simply having a thought" which aims to promote understanding that it is just simply a transient thought (akin to "background noise") which is one of tens of thousands which are commonly experienced each day (Harris, 2009).

Defusion is particularly relevant to PSA as the fusion or integration of common negative thoughts is typically a significant factor in the way that clients may fuse or buy into stories and experiences of their past which may lead them to feel stuck or unable to move forward Eifert, Forsyth, 2005). Avoidance of speaking in public has been found to be associated with past painful schemas one such schema may involve memories, images, feelings and beliefs about presentations (Beck et al., 1985; Swain et al., 2013; Hoffmann & Otto, 2008). Such memories may play some part in maintaining PSA.

The ACT therapist would not go into debating facts from within a client's life story and experiences but would instead focus on exploring what purpose such experiences serve with regards to moving forward to their valued direction. It is suggested that by undertaking this exploration, it is said to be helpful by decreasing the control that such cognitions impact upon the client's behaviour (Hayes & Smith, 2005).

1.15.3 Being Present

The state of "being present" is defined as "a flexible and voluntary attention to internal and external events as they are occurring, without placing attachment, evaluation or judgement" (Harris, 2009). Being present entails three important skills: (i) the ability to bring attention

to the here-and-now; (ii) openly and fully experiencing that which is occurring and (iii) describing these events in a non-judgemental way (Hayes et al, 2006). Common examples of not being present may occur whilst ruminating about past events (performance) or worrying about forthcoming events (anticipation) such as a public presentation task. The emotional distress impacts reported by clients have been found to extend beyond the actual time spent in a given social situation. Research has suggested that the socially anxious person has a heightened self-focus of attention and engages in anticipatory and post-event processing (Rachmann, Gruter- Andrew, Shafran, 2000; Kocovski, Endler, Rector, & Flett, 2005). Further, they may have a heightened recollection of failure associated with past events and thus deeper rumination of that social event, which tends to further reinforce the intrusiveness interfering with concentration (Wells, 2007).

Thus clients with PSA are encouraged to recognise when they are not aware of the present moment and to notice the intrusive past performance/anticipatory thoughts and to then refocus their attention to their current inner-experiences and events in their current environments, to adopt a non-judgemental stance as they occur. The aim is to teach clients to be more flexible, curious, non-judgemental and to pay attention to the here-and-now; to have conscious attention of their inner psychological world and their surroundings (Eifert & Forsyth, 2005). This attentional training is said to be beneficial in improving executive control, redirecting attention and re–orientation whilst negating the automacity or habitual process in the brain. (Goldin & Gross, 2010). This eventually develops new neural pathways within the brain which may help individuals to no longer automatically respond their external experiences with anxiety and fear (Goldin & Gross, 2010).

1.15.4 Self as Context

The self-as-context process is directly related to Relational Frame Theory (Hayes et al, (2001). As discussed previously (see 1.11.2), individuals will, over time build coherent stories about themselves (such as "I am a failure") created by their mindset, childhood experiences and interactions with others. These self-coherent stories describe their being. Attachment to this conceptualised-self will rigidly govern behaviours in certain contexts, for example public speaking; it also increases biases such as a tendency to focus on certain internal and external cues in social situations (Wells, 2007, Hayes et al, 2006). In ACT, developing "self-as- context" allows a person to get in contact with self-as-context, as a secure, stable and continuous version of "I" and thus capable of letting go of their attachment to, or fusion with previously unhelpful versions of who they "were" within certain contexts. This is achieved by undermining the effects of unhelpful stories, memories, thoughts and feelings that they have had about themselves, a conceptualized self (Hayes, et al., 2006).

Hayes et al (2006) postulated that with this process ACT helps individuals to get in contact with the "transcendent sense of self*"* known as "self-as-context" which represents a consistent, secure and continuous 'I' from which events are experienced but which is separated from those events. This means that "the self" is an observing and experiencing self which is distinct from self-defined thoughts, feelings, sensations, stories and memories (Harris, 2009). That is, experiencing thoughts and feelings as extrinsic mental events, not an unhelpful intrinsic part of the aspect-of-self or an accurate reflection of physical reality. This reconfiguring of the self is primarily conveyed through the use of mindfulness exercises. Clients with PSA are invited to turn their attention towards their experiences and explore them from an observer stance, not trying to push them away, not engaging with them, just noticing as a part of their current experiences (Harris, 2009). For example in

promoting self-as-context, the idea of the observer-self is discussed as being distinct from a thinking-self. This can be combined with mindfulness exercises such as the "Leaves on a stream" exercise (see, appendix 16, exercise 10) where the client ask to focus on their breathing and observes their thoughts with openness and curiosity, without judging them and holding on to them, simply letting them pass by like watching a leaf flowing pass on the surface of a stream (Hayes et al., 1999).

1.15.5 Values

Hayes et al (1999) defined values as "verbally desired global life consequences" (p.206). Values in ACT serve as free choices and dynamically evolving intentional actions that are perceived to be enhancing and improving the quality of life. While values are assumed to be shaped by the learning history of the individuals they never refer to specific actions, but rather function as over-arching, guiding aspirations in the person's life (Hayes et al., 1999).

A recent study revealed that individuals with SAD reported a considerable amount of dissatisfaction with their lives which may be linked to a lack of value-based living (Eng, Coles, Heimberg, & Safren, 2005). As discussed, persons experiencing PSA may become fused with their internal experiences and conceptualised self, leading to avoidance of public speaking situations. This avoidance exerts control over behavioural repertoire leading to increasingly limited free choice and engagement in dispiriting actions such as quitting a job or deciding not to take up training or educational modules requiring public speaking tasks (Hooper et al., 2012; Wells, 2007).

Compared to the general population, persons experiencing PSA appear to be more prone to experiencing unemployment and to have reduced post-education involvement (England et al., 2012). An important part of ACT is to enhance an individual's effectiveness in pursuing

personally held values and to keep commitments for behaviour change (Hayes et al., 2012). ACT clients are encouraged to identify and reconnect with their deeply-held personal values, desired qualities and goals, to choose their valuable directions in broader domains. This is in order to better guide their journey and may include the family/education/ career and employment domains. At the same time, efforts are made to recognise and ameliorate the impact of the "forced choices" such as avoidance, social compliance and life traps. As the client begins to identify important values, they often recognize how previous anxiety management behaviour had prevented them from being able to enjoy their preferred life values.

1.15.6 Committed Action

Committed action is one of the key components of ACT, it involves individuals to take effective action toward their chosen values (Harris, 2009). In this regard the ACT therapist will invite a client with PSA to notice their actions which are not consistent with their values and encourages them to return back to valued living. As discussed (Section two) avoidance behaviour is one of the main characteristics of anxiety-related difficulties (DSM-V 2015, NICE, 2013). Similarly individuals with PSA tend to show unwillingness to remain in contact with their unwanted inner experience s, to use avoidant coping strategies to alleviate their distress (Hayes et al., 1999) and which may prevent them from taking committed actions towards their values. This can have long-lived adverse impacts such as lower academic achievement limiting the potential for career successes (England et al., 2012; Aderka, 2012). The goal of ACT is to encourage people to accept the unwanted inner experiences and focus on behavioural change in their valued direction. ACT uses traditional behavioural strategies: assertiveness training, social skills training, exposure and goal setting. ACT also makes use of various metaphors for example, the "Anxiety tiger" (see

Appendix-15, handout 1) and experiential exercises such as the “Leaves on a stream” (see Appendix-16, exercise, 10). However, it is worth noting that, unlike classic exposure exercises, (which are conducted to promote the extinction of distress) exposure exercises in ACT are utilised to encourage individuals to be present with their feared or disturbed private events and engage in value guided behaviour (Hayes et al., 2006). As discussed (Section two) psychological inflexibility/ experiential avoidance is the main characteristics of anxiety related difficulties (DSM-V 2015 ; NICE, 2013) in which the individuals show unwillingness to remain in contact with their unhelpful/unwanted inner experiences and take steps to use avoidant coping strategies to alleviate their distress (Hayes et al., 1999).

In summary, the ACT perspective aims to foster psychological flexibility through its core processes. Although symptoms of PSA can have a serious impact on valued living, as such ACT does not set out to directly target them. However, their functional consequences with regards to behaviour are. ACT encourages the client to view and understand their relationship with their internal experiences, to be open to the whole experience while actively living a value-consistent life. Thus, ACT promotes understanding, such that individuals can, if they choose, manage behaviour no matter how strong anxiety-related feeling are. In this way, ACT helps a person to change their relationship with their otherwise unworkable symptoms or reactions so that painful experiences need no longer hold them back from more effective living. Whilst objective detachment is key, any actual symptom reduction (such as through increased confidence) is deemed to be a bonus rather than the primary aim of the therapy (Harris, 2009). The main purpose of ACT therapy is therefore to encourage the client to willingly accept unavoidable experiences whilst making essential and strong connections to living more in accord with their chosen values (Harris, 2009).

1.16 Outline of Historical Conflict between ACT and CBT

The discussion below provides an overview of the historical conflict between ACT and CBT with regard to the relative merits and disadvantages of each approach. It also provides evidence of efficacy to support use of the ACT model in both the treatment and longer-term management of SAD and PSA.

Traditional cognitive behavioural therapy since Beck et al (1979) continues to occupy a dominant role in evidence-based practice. However there have been several issues within the traditional CBT model which has given rise to the evolution of a wide range of so-called "third-wave" approaches for which examples include: DBT (Linehan & Kehrer, 1993); MCBT (Segal, Williams, & Teasdale et al., 2002) and ACT (Hayes et al., 1999). This third-wave movement emerged at a time when debate had arisen over whether direct disputations of irrational thoughts or cognitive reappraisal was actually beneficial to clients.

Critics argued that such cognitive restructuring invalidated the client's experiences and appeared to be unempathic (Linehan & Kehrer 1993). Other critics argued that attempts to alter dysfunctional cognitions and realign them with reality, contrary to expectations, actually increased the re-occurrence of negative thoughts rather than altering them (Hooper, Davies, Davies, & McHugh, 2011; Hayes et al., 2006; Wegner, Schneider, Knutson, & McMahon, 1991). A meta-analysis study was conducted by Abramowitz et al (2001) which examined the effects of the magnitude of thought-suppression across controlled studies. This analysis found support for the role of cognitive dispute or appraisal in leading to an excessive focus on unwanted internal events which could, in turn, cause an increase in the re-occurrence of those unwanted thought and emotions.

ACT was one of the emergent behavioural therapies arising from the third-wave movement. It has its roots in Relational Frame Theory (Hayes et al., 1999) and has attracted a great deal of interest. However as it became more popular and moved towards the mainstream psychology landscape there have been extensive discussions and debate from within the academic community over its empirical status and whether it really provides any truly evolutionary ideas (see Arch & Craske, 2008). It may be that the use of the term "third-wave" had created misperceptions such that CBT proponents had perhaps become concerned that CBT was simply being replaced with something more "fashionable" and something of an interesting novelty as discussed by Arch & Craske (2008); Corrigan (2001); Hofmann & Asmundson (2008) and others. It was Hofmann & Asmundson (2008) who conducted a review comparing ACT with CBT in which they suggested that the founders of ACT had misunderstood CBT and had thus espoused the view that ACT and other third-wave approaches had brought nothing new to the psychology field, that is, ACT did not really represent an entirely new therapy approach. However, Hayes (2008) argued that the "third-wave" does not imply hostility and a rejection of the first and second waves of behavioural and cognitive therapy (Hayes, 2008 p.292) but rather that it aimed to address perceived weaknesses. He further explained that ACT "transcends the distinctions between behaviour therapy and cognitive therapy" and "reformulates and synthesizes previous generations of behavioural and cognitive therapy" in order to move them forward rather than attacking (Hayes, 2008, p.292).

Opponents of ACT based their conclusions on the observation that ACT employed familiar emotion regulation strategies that were similar to CBT and further that there was also a lack of hard data to support the efficacy of ACT (Hofmann & Asmundson, 2008). They concluded that ACT shared much in common with CBT appearing to have only minor

variations to established CBT methodology. However, whilst proponents of ACT consider that ACT does share similarities with CBT, they also believe there are very distinctive differences. Hayes et al (2011) proposed several distinctive features of contextual approaches such as ACT compared to CBT such as (i) emphasis on acceptance rather than change of the internal events while pursuing valued living and behavioural change in the service of deeply held values. (ii) focus on the function more than the content of the internal events (iii) focus on improving quality of life rather than the symptoms reduction (Hayes, Villatte, Levin, & Hildebrandt, 2011).

From the above, while it can be concluded that ACT does share features with cognitive behavioural therapy; including the importance of establishing an active, collaborative therapeutic relationship and a grounding in empirical validity of interventions, there are also significant differences. One key difference may be found in the philosophy, treatment approach and mechanism (Ruiz, 2010). For example, ACT gives significant weight to the consideration of the contextual factors in the development and maintenance of anxiety-related problems. This is in clear contrast to CBT which tends to overlook this aspect and to attribute the problematic behaviours to internal predispositions such as dysfunctional thoughts and beliefs.

Another way of highlighting the differences between ACT and CBT can be seen in the manner by which CBT is concerned with eliminating distress through active thought-modification and emotional control which adds an additional cognitive burden whereas ACT emphasizes facing painful events in an accepting way and encourages behavioural willingness and committed action (Arch & Craske, 2008). For example with regards to managing PSA, CBT will place emphasis on the modifications of thought-processes using cognitive restructuring, behavioural experiments and exposure; this contrasts with ACT

which will place an emphasis on accepting the anxiety "as it is" without the need for it to be modified, which allows the individual to devote more energy to pursuing valued living. The exposure component in ACT is about increasing one's willingness to engage in valued life goals rather than aiming simply for habituation and a behavioural experiment to test beliefs (Kocovski, Fleming, & Rector, 2009). Within ACT there is no aim or intention to spend effort disputing or labelling thoughts as negative or positive; instead clients are encouraged to adopt an observer-stance to distance themselves from adverse thoughts whilst at the same time pursuing a valued life. This is the key reason why ACT and CBT are functionally different from one another (Ruiz, 2010).

Another criticism of ACT was provided by Ost (2008). Ost had conducted a meta-analysis review comparing a set of third-wave randomized controlled studies with a set of traditional CBT studies. In the ACT category he examined thirteen RCTs with a total of 677 participants. He concluded that ACT did not fulfil the criteria for being an empirically valid intervention due to its methodological deficits in comparison to CBT such as the lack of controlled trials. The findings of Ost (2008) have been subject to criticism due to serious methodological limitations in the reviewing process, and bias. For example Gaudiano (2009) re-analyzed the review of Ost (2008) and argued that the comparisons made did not follow justifiable criteria and were distorted because he had made errors in the coding and matching process. Gaudiano (2009) argued that 38% of the ACT studies would not match with the CBT studies because the studies were across different disorders and using different populations. For example the populations that were treated in the ACT studies included more difficult psychological difficulties such as psychosis, personality disorders, substance abuse, chronic medical conditions, whilst the CBT studies included one case of depression and eleven cases of anxiety (Ruiz, 2010). Such comparisons are completely inappropriate

because disorders such as psychosis and stress are completely different disorders in nature and may require different study designs and methodologies (Gaudiano, 2009).

The Gaudiano (2009) review also suggested that Ost (2008) had failed to take into account the practical issue of funding differences between ACT and CBT research. CBT studies typically received much larger amounts of funding when compared with ACT. This has placed ACT studies in a more disadvantageous position as having more money available allows researchers to design much more robust studies having the best methodological procedures. In support of this argument, Gaudiano (2009) in a re-analysis found a positive correlation with funding and methodological stringency.

Despite the flaws with the review by Ost (2008), the critique it provided was informative and important in pointing out methodological weaknesses in the early studies on ACT. His criticisms has been taken seriously by ACT researchers such as Kocovski et al (2009), encouraging efforts to design more robust research and thus to advance the empirical status of ACT. Funding constraints aside, there are still significant technical criticisms to address. Consideration must be given to weaknesses identified prior to the Ost (2008) findings. Hayes et al (2006) in their review of ACT studies highlighted methodological limitations such as lack of controlled trials, insufficient funding and had encouraged researchers to work towards addressing these issues (Gaudiano, 2009).

New ideas often meet with a great deal of resistance when they first appear, as established researchers will have invested a considerable amount of personal effort in the pursuance of their own work. There will also be very real concerns around the robustness of initial studies arising from limited initial funding and possibly over-hasty implementation of studies (Hayes et al., 2006). Early concerns with the efficacy of ACT were thus likely to comprise

a complex mix of political and technical factors. Taking a pragmatic approach, this is quite understandable, it will take time and other valuable resources to further explore and develop the potential of ACT. In support of this, Gaudiano (2009) suggested it is normal for any new psychotherapy approach to have methodological limitations arising from limited funding at the early stage of trials. The early criticisms of ACT as discussed above have been addressed in more recent studies. ACT is now recognized as an empirically supported intervention, based upon robust research methodologies. There have been significant quality improvements with regards to competency and adherence to treatment monitoring (Smout, Hayes, Atkins, Klausen, & Duguid, 2012).

Some might argue that even if ACT is different in some way that it is superfluous because existing, well-developed treatment methodologies work just as well. On this point, the efficacy of ACT has been compared with existing interventions. For example, a meta-analysis of ACT was conducted by Arch et al (2009). They reviewed the empirical status of ACT by investigating eighteen RCTs and the result of this review suggested that while ACT was better than the wait-list and placebo conditions with a moderate effect size, it was not significantly better than established treatments such as CBT (Arch, Powers, Zum Vörde Sive Vörding, & Emmelkamp, 2009). These inferences have been challenged; Levin & Hayes (2009) re-analysed the data and concluded that ACT was actually better than established treatments (Ruiz, 2010). A more recent meta-analysis assessing ACT efficacy in thirty-nine RCTs, found ACT to be more effective than treatment as usual or placebo, and to be as effective as traditional treatments such as CBT in treating depression, anxiety, somatic health difficulties and substance abuse (A-Tjak, Davis, Morina, Powers, Smits, & Emmelkamp, 2015).

In further support of ACT as a valid approach, the American Psychological Association Division has listed it as one of the twelve empirically-based treatments (APA, 2012) with moderate support in depression and strong support in pain. ACT now appears to be a valuable model of therapy and increasingly gaining great popularity in clinical practice and the wider research arena (Ruiz, 2012). In the UK, ACT is also gaining popularity, it has a large special interest group operating within the British Association for Behavioural and Cognitive Psychotherapies.

1.16.1 Empirical evidence for the ACT model

Studies of the efficacy of ACT in the treatment of SAD suggest that it may likely be effective for PSA. There have been studies investigating the role of discrete ACT processes (typically, acceptance; defusion; self as context; values; contact with the moment and committed action) in the management of psychological difficulties. Studies of the ACT model conducting correlational, process of change and components analysis have provided evidence for its use across a broad range of problems ranging in scope from intrinsic health factors such as psychosis to extrinsic environmental factors such as work-related stress (Hayes, et al., 2006).

Such studies suggest that expanding the awareness of ACT processes (see above) acting in concert offers further scope for the introduction of additional tools to assist with improving the lives of people experiencing a range of psychological difficulties. As with any research, ACT studies that are able to clearly demonstrate favourable clinical outcomes should be properly funded, of a robust design, and be able to stand up to critical scrutiny. Poorly funded, weakly designed studies would simply prolong the debate without actually achieving very much. For example, recent work has provided evidence to support use of the

ACT model but studies performing process analysis have focused on discrete single processes that, whilst they make an important contribution to the development of successful therapeutic interventions, do not tell the whole story.

This section will concentrate upon research developments that have examined ACT core processes. Early studies primary focused on acceptance, values and defusion but later studies have also examined other components (Hayes et al., 2006).

In the first study, Masuda et al, (2004) investigated the impact of a cognitive defusion technique upon negative self-referential thoughts using the "Milk, milk exercise*"* (Hayes et al., 1999, p. 154-155; Masuda, Hayes, Sackett, & Twohig, 2004) in which clients were asked to quickly repeat negative self-referential thoughts aloud until losing its meaning. The defusion technique was compared to a distraction task or to a thought control task that consisted of instructions to shift attention to more helpful thoughts and through abdominal breathing training. The results of the study found that the cognitive defusion technique reduced both discomfort and believability of negative self-referential thoughts. This may have implications for studies examining SAD/PSA as discussed in section 1.6.1 where clients with SAD/PSA experience negative self-appraisal/core beliefs, for example, "I am a failure" (Clark & Wells, 1995).

Najmi et al, (2009) investigated the role of acceptance, examining the link between intrusive thoughts and suppression in participants with Obsessive Compulsive Disorder (OCD). Participants were assigned to three groups and instructed to deal with their intrusive thoughts using (i) focused distraction (ii) suppression and (iii) acceptance. This study found that suppression was counter-productive in dealing with intrusive thoughts in OCD. Participants using high levels of acceptance and focused-distraction coping strategies

experienced less distress than the suppression group. This indicated that training in acceptance can help people with OCD and intrusive thoughts (Najmi, Riemann, & Wegner, 2009).

With regard to the role of acceptance upon emotional processing, Bond & Bunce (2000) showed there were positive effects for the use of an ACT intervention when dealing with stress. This study showed that acceptance training reduced stress. Similarly, in an early study McCracken, (1998) found that higher acceptance of pain was correlated with lower pain experience, less pain related depression, anxiety, avoidance and less overall depression. Results had also showed improvements in physical and psychosocial functioning together with work status.

In other research, Bahraini et al (2014) investigated the role of values in a war veteran population experiencing suicidal ideation. They found that identifying values and engaging in valued-living was a protective factor against suicidal ideation in the ex-military, war-veteran population (Bahraini, Devore, Lindsey, Bensen, Foster, & Brenner, 2014).

With regards to social anxiety, Block (2002) compared an ACT intervention with CBT and a wait list for clients with SAD/PSA. The study found improvements in both CBT and ACT condition over the wait-list control, however further investigation revealed that ACT participants reported larger reduction in distress and avoidance during public speaking and reported more willingness to experience anxiety than the CBT group did.

Similarly Ossman et al (2006) in a clinical outcome study examined the efficacy of ACT for SAD which reported that changes in ACT interventions including acceptance and committed action mediated improvements in social anxiety. Despite value-clarification being one of the core process of ACT, there has to date, been little research examining the

role of value-clarification in promoting change, thus it is clear that more research is needed here.

In a study by Niles et al (2014), they investigated the relationship between session-by-session mediators including negative cognitions, experiential avoidance, and the treatment outcomes in ACT and CBT for managing SAD and depression. Fifty participants from a clinical population were randomly assigned to one of three conditions: ten sessions of ACT, ten sessions of CBT or a twelve week waiting period. Assessment included: completing self-report measures, clinician's ratings and a public speaking task. Multi-level analysis was used to examine the difference between groups. The results showed a greater decrease in experiential avoidance for ACT when compared to CBT. Negative cognitions were reported to have decreased for both treatments (Niles, Burklund, Arch, Lieberman, Saxbe, & Craske, 2014).

Following these studies, the acceptance, defusion and values components seemed to be linked to an active process contributing to clinical improvements. More research is clearly needed to investigate the role of single components and their interaction with processes in the context of ACT when applied to treating SAD and more specifically PSA.

1.16.2 Summary of criticism and empirical research

ACT has been criticized for technical shortcomings in the design and implementation of early studies intended to examine the efficacy of this approach. It has been pointed out that initial research was often marred by over-hasty, poorly planned ventures and in common with many new areas of research, had suffered from a lack of funding necessary for robust design in the early studies. There is now a sufficient body of work investigating this field to merit more in-depth research. Further, there are now recognized shortcomings to CBT which

has increased the interest of researchers in the potential for ACT to offer inspiration and hopefully, practical solutions to currently, seemingly-intractable problems.

The ACT model and its associated six core-processes brings a new and fresh perspective, demonstrating that there can be real benefits to developing a more acceptance approach, that is, a much more "user-friendly" experience for the individual in contrast to the added effort which can be demanded by other therapeutic methodologies. ACT is shown to be effective in the treatment of a wide range of psychological issues. It continues to be among one of the most researched of the newer approaches with a CBT-heritage (Ruiz, 2012**).**

ACT processes are inter-dependent and complement each other to create psychological flexibility to deal with emotional difficulties. Based on the component analysis research discussed above it is clear that ACT is associated with enhanced acceptance and psychological flexibility (Moore, Stewart, Barnes- Holmes, & McGuire, 2015); reduced experiential avoidance (Block, 2002); improvement in quality of life (Bahraini et al., 2014) and enhanced cognitive defusion (Bach & Hayes, 2002).

One strength of ACT appears to be its breadth of applicability (A-Tjak et al, 2015) this promise of versatility is a key reason why it has been adopted for this PSA study. ACT has been found to be effective not only for managing psychological issues such as anxiety and depression, but also physiological issues such as managing chronic pain (Ruiz, 2010), cardiovascular recovery and managing food cravings (A-Tjak et al., 2015).

It is true that the Ost (2008) critique is applicable to many SAD and PSA-specific studies. Thus there is an on-going need for further methodologically robust studies using randomized controlled trials, employing different modes of delivery such as self -help, individual and group based interventions and to also investigate the shorter (ultra-brief-less than 6 session)

versions of ACT-based interventions. The latter would be potentially very beneficial, as ACT research in this field especially in PSA is scarce and if proven to be effective, brief interventions using different delivery modalities could potentially improve access and lower delivery costs. In the UK, there has been debate over how best to promote recovery and make evidence-based psychological interventions widely available at lower cost (NICE, 2013). Given the prevalence and impact of PSA within the general population and among university students, there is a pressing need to consider ways of improving access and implementing effective interventions and training packages. Moreover, due to restricted funding, resources, time limitations and the high cost of training and supervising therapists in sufficient number to meet high demands, the development of a standardized-format intervention that is potentially cost effective, readily accessible and time efficient would be greatly beneficial.

ACT principles have previously been used in brief interventions and found to be effective in the treatment of depression (Zettle & Hayes, 2002), social anxiety (Dalrymple & Herbert, 2007) and psychosis (Batch & Steven, 2002, Johns, Oliver, Khandoker, Byrne, Jolley, Wykes, Joseph, Butler, Craig, Morris, 2016). However, ACT research comparing the effectiveness of different delivery modalities for PSA is scarce. This is surprising given that delivery-formats might readily be re-designed to improve dissemination across a larger, more diverse population. Clearly there is scope for careful design of an ACT intervention delivery-format that would provide a means to deliver standardised therapy to clients with minimal therapist input. Further, it is already well-established that the use of guided self-help interventions have similar positive treatment outcomes as for individual therapy in both clinical and community populations (Andersson & Titov, 2014). Similarly group based interventions are found to be more cost-efficient than one-on-one therapy and may also

provide additional benefits of vicarious learning, social support and normalisation (Johns et al, 2016). In a recent study, Johns et al (2016) examined the feasibility and acceptability of a brief (four hours) ACT group intervention for individuals with psychosis. Eighty three participants were recruited through a community mental health team. The results showed that brief group therapy for psychosis is feasible, accessible and is consistent with the ACT model. Participants had reported increased psychological flexibility and clinical improvements in both functioning and mood from baseline to follow up.

Johnson et al (2010) investigated the effectiveness of ACT self-help intervention for people with chronic pain. Participants using the self-help format read the work-book over a six-week period. When compared to the control group, results showed that participants who completed the self-help work-book had showed significant improvements (with large effect size) for the quality-of-life measure and also had indicated a reduction in their anxiety levels (Johnson, Foster, Shennan, Starkey, Johnson, 2010).

Similarly, Fledderus et al, (2012) evaluated the effectiveness of a self-help interventions programme based upon ACT and designed to help people with moderate depression. Compared to a control group, participants who completed the self-help program showed a reduction in their reported depression and experiential avoidance together with an increase in the quality- of-life measure. The results also indicated that the effects were sustained at a three-month follow-up (Fledderus, Bohlmeijer, Pieterse, & Schreurs, 2012).

Studies thus far have demonstrated the usefulness of self-help and group based interventions as an option for treatment delivery. This is promising but studies to-date based upon ACT

are still limited. Comparison studies to investigate the relative merits and disadvantages of the different delivery modalities of ACT are sparse.

Given the possibilities, of increasingly brief forms of established therapies that retain their effectiveness through optimized delivery formats, to address the issue of otherwise limited accessibility, much more research in this area is essential. At the present time, increasing delivery costs in a difficult economic climate are actually reducing accessibility to therapies and therefore further ACT research is much-needed in the PSA field to evaluate the efficacy of briefer and readily disseminable variations of ACT including assessment of the efficacy of self-help-format interventions relative to individual or group interventions.

The next section will examine the effectives of ACT for SAD and PSA in order to demonstrate the basis, foundation and rationale for this current study and will identify the areas that may need further investigation.

1.17 Effectiveness of ACT for SAD / PSA

ACT has been widely researched in the context of CBT modalities. A recent meta-analysis showed that there is a supportive and growing body of evidence for the efficacy of ACT (Hayes et al, 2006; Ruiz, 2010; Ruiz 2012). It has been applied to a variety of psychological issues and found to be effective for anxiety disorders (Codd, Twohig, Crosby, & Enno, 2011) depression (Tamannaeifar, Gharraee, Birashk, & Habibi, 2014) psychotic disorders (Bach & Hayes, 2002); eating disorders (Juarascio, Forman, & Herbert, 2010) and also for chronic pain relief (McCracken, 1998).

Currently, several studies have investigated the efficacy of ACT for social fears including PSA. In the first study Ossman et al (2006) conducted a pilot study investigating the

effectiveness of ten sessions of ACT-based exposure group treatment for SAD. The therapists were doctoral students who received training in ACT and supervision. Twenty-two participants enrolled in the group treatment but only twelve participants completed treatment. The attrition rate was high due to participants` reported experience of severe agoraphobia. Post-treatment and follow-up data from this study revealed significant decreases in the symptoms of social phobia and experiential avoidance measures and found an increase engagement in life values. The result from this study indicates that ACT was feasible and acceptable to treat social anxiety and may increase engagement in values and quality of life. However, a high dropout rate limits the study. Additionally, the therapy sessions were not recorded therefore it is unclear how consistent the actual therapy was to what was reported.

Dalrymple & Herbert (2007) conducted a pilot study using a clinical sample who met DSM-IV criteria for SAD. A treatment programme incorporated a standard exposure-based treatment into ACT in order to examine its acceptability and preliminary efficacy. The treatment program was delivered in an individual format, in a one-hourly session per week over twelve weeks. Nineteen individuals diagnosed with SAD participated in a twelve week comprehensive program integrating exposure exercises into the ACT protocol. Therapists were clinical psychology doctoral students and received regular supervision. Ten percent of the sessions were audiotaped for supervision. The results revealed that the ACT based exposure treatment produced significant improvement from pre-treatment to follow up on self-report measures of SAD symptoms. Participants in this study also reported better social functioning, improved quality of life, enhanced social skills and a decrease in their experiential avoidance. The study found large effect-sizes for the outcome self-report

measures with an average pre to post treatment effect-size = 1.00 and pre-treatment to follow up effect-size of 1.29.

Dalrymple & Herbert (2007) argued that these effects-sizes were similar to those obtained in previous CBT studies for SAD (Heimberg et al., 1998). This study concluded that the changes in social anxiety symptoms were mediated by a decrease in experiential avoidance-based coping. This study has revealed significant results showing that ACT can be effective in the treatment of SAD and reduce avoidance and improve quality of life. However, an acknowledged limitation of this study was to use a small sample size which renders it difficult to generalise with regards to larger populations. However it obtained large effect sizes on the social anxiety, experiential avoidance, valued living and also had low attrition rate. Another limitation of this study is the absence of a control group or alternative intervention comparison which makes it difficult to ascertain whether the results can be attributed particularly to ACT. This study was also lacking in a comparison group. New studies that directly compare ACT with empirically well-established treatments such as CBT may produce a better picture with regards to the efficacy of ACT.

Kocovski et al (2013) compared the effectiveness of mindfulness and acceptance-based group-therapy (MAGT) with Cognitive Behavioural Group Therapy (CBGT) for individuals experiencing social anxiety. One hundred and thirty-seven participants were enrolled. Therapists were a psychologist and a psychiatrist who had trained in ACT and MAGT. This study compared CBGT to MAGT with a wait-group. One hundred and thirty-seven participants were randomly assigned to either CBGT, MAGT or the wait-list control group. Social anxiety, cognitive reappraisal, mindfulness, acceptance, valued living, depression and rumination were measured at pre, mid, post and three-month follow up periods. The treatment involved twelve weeks of two- hour sessions and a three-month follow-up with a

brief recap-session. The CBGT group involved; cognitive restructuring and exposure exercises. The ACT-based group included elements of mindfulness and acceptance exercises, cognitive defusion and willingness to experience anxiety.

The results showed a significant decrease in social anxiety, rumination, depression and significant increases in mindfulness and acceptance within both groups in comparison to wait-list control. The gains were maintained at the three-month follow-up. The findings of this study suggested that MAGT is comparable to CBGT and can be an alternative to traditional CBGT for the treatment of social anxiety. The study recruited a large sample size (n=137) however only sixty-nine participants (CBGT=32, MAGT=37) completed the treatment. Attrition rate appears to be the main acknowledged limitation in this study and this impacted on their follow up data. Only half of the participants provided follow up data. Reported reasons for discontinuation of the treatment were due to work commitments, deciding to take individual therapy instead and other unknown reasons. Despite the limitations their results provide support for the mindfulness and acceptance based approaches as an alternative treatment to cognitive behavioural group therapy.

With regards to studies specifically examining PSA, Block & Wulfert (2000) designed a group-based pilot study to compare CBGT to ACT and wait-list control. Eleven participants with public speaking anxiety were recruited and were semi-randomly assigned to four weeks of ACT or CBGT or wait-list control. Both groups included exposure exercises such as giving a speech in groups. The results indicated a reduction in symptoms of PSA and SAD among both CBT & ACT interventions. There was no change in the wait-list group. This study did have a number of limitations, for example there was no statistical test to assess the significance level due to a small sample size and further, it heavily relied on the self-report measures. Block & Wulfert (2000) concluded that despite the promising results, their

findings needs to be interpreted cautiously as their data relied on self-reporting and verbal responses which may have been influenced by social desirability.

Block (2002) designed another group-based study addressing the limitations in their previous pilot study. The study aimed to investigate the comparative efficacy of ACT and CBT upon public speaking relative to a wait-list control. Thirty-nine undergraduate students with moderate PSA were recruited and semi-randomly assigned to the six weeks of ACT or CBGT or wait-list control. Therapists were doctoral students in clinical psychology and received supervision. Results indicated that the participants who received ACT evidenced a decrease in their behavioural avoidance and an increase in reported willingness to engage in public speaking activities. This was measured by use of a willingness questionnaire which was developed by Block & Wulfert (2000). The study also found a decrease in students` general social anxiety symptoms during the exposure exercise in which participants were asked to do a 10-minute presentation in their groups as compared with the control group. The study revealed similar results for the CBGT group however, the ACT group showed a significant decrease in behavioural avoidance which was evidenced by ACT participants` increased speech length, larger reductions in distress during speech task while CBT did not. The results provided support for experiential avoidance (EA) which was measured by AAQ. However, findings related to mechanism of change was inconclusive as there were no significant changes after the treatment on measures that were related to ACT measures; such as quality of life in comparison to control group. This study shows that ACT as a group-format is amenable for SAD/PSA and there is a need for further research to examine if EA is a potential mechanism of change with regard to ACT.

Although the results have been promising, there are some limitations to this study; firstly, it used non-clinical candidates which makes it hard to draw general statements about the

differentiation of ACT and CBGT. It lacked an independent evaluator because all data were based on the self-reported fear and willingness rating. Finally in this study, there was no mention of extraneous variables such as, if any participants use medication, or receive other therapies simultaneously. Despite these limitations, the Block (2002) study offers a worthwhile avenue for future research. Conducting replication studies with larger samples would be beneficial to assess whether the research findings are applicable and transferable to particular settings.

Beharry (2008) investigated the effectiveness of ACT deployed as a guided self–help format for PSA. Results showed that the use of the self-help book, together with regular therapist contact, increased self-reported willingness to approach public-speaking situations and an improved quality of life. Results also showed a significant reduction in anxiety measures and experiential avoidance. This study was limited by a number of factors, such as no base-line screening to measure the levels of social anxiety and that PSA had not been formally assessed via psychometric measurements. Thus it was an unknown regarding whether the participants had met the social anxiety criteria. There was no exposure element in this study, participants were not asked to engage in public speaking situations which would have made it difficult to obtain a behavioural measure of willingness, avoidance. Another limitation of this study was that there were only eight participants, which limited the scope for generalising their findings to the wider population.

England et al (2012) examined the acceptability and feasibility of a brief acceptance-based group exposure treatment for public speaking anxiety, in comparison to standard habituation-based exposure. This study recruited forty-five participants from a clinical population meeting DSM- IV criteria for non-generalised SAD which was based on the

clinical interview. Thirty-five participants completed the study. Therapy was delivered in a group format over a one-hour session per week for six weeks. Therapy was provided by three graduate students who were supervised and trained in both therapy modalities. Participants were randomly assigned to either habituation focused exposure (HAB) or acceptance/defusion. The results showed that ACT was comparable to HAB, both groups demonstrated significant improvement in "confidence, speech related cognitions, public speaking confidence, anxiety and clinician rated social skills on a behavioural speech task" (England et al., p.66). The findings of this study were significant offering moderate-effect size across the measures and most significantly was the first study to offer exposure-based ACT to a clinical population. However, the most important acknowledged limitation of the study was the use of a small sample size which resulted in lower power statistical analysis.

Goldfarb (2010) in an RCT study examined the effectiveness of acceptance vs cognitive restructuring. College students with public speaking anxiety were recruited to participate in the study. Participants who met inclusion criteria for social anxiety (SIAS; Mattrick & Clark, 1998) and for PSA on the Leibowitz Social phobia Scale (Liebowitz, 1987) were randomly assigned to a single fifteen-minute group session of either acceptance-based cognitive intervention, cognitive restructuring or a psycho-education control group. Participants were asked to deliver a speech as a behavioural measure. The study found no significant difference between the three groups. The main limitation was the duration of the therapy, as a fifteen-minute intervention may not be sufficient time to create any significant change between the groups (Swain, 2013).

1.18. Summary and conclusions

In summary, the bulk of evidence from the above eight studies appear to suggest that ACT is effective for the treatment of SAD and PSA among both clinical (see Dalrymple & Herbert 2007; England et al., 2012) and non-clinical populations (see Block, 2002; Beharry, 2008).

Evidence also suggested that ACT for SAD and PSA was superior to control conditions (Block, 2002) and was comparable with the established treatment modalities such as CBT, Habituation Based Exposure Approach (HAB) (England et al., 2012; Block, 2002).

ACT studies for SAD also showed that ACT was effective when delivered either in group (Block, 2002); individual format (Dalrymple & Herbert, 2007) and as a self -help format (Beharry, 2008). Follow-up evaluations also provided support for ACT in the treatment of SAD and PSA (Block, 2002; Kocovski et al., 2009, 2013). The ACT research base for generalised-SAD is associated with statistical and clinical significance (Swain, 2013, p.959) yielding large effect sizes (Kocovski et al., 2013).

Whilst published ACT studies specifically examining PSA are scarce, those that are available have produced promising results in the treatment of PSA as shown above. However most of these studies are found to be methodologically less rigorous than most of the SAD studies mentioned above (Swain, 2013).

The methodological caveats have included: having a small sample size yielding small effect sizes (Beharry, 2008; Goldfarb, 2010); no statistical test to assess significance (Block & Wulfert, 2000); absence of standardised measures (Beharry, 2008) and no control group or alternative treatment group (Beharry, 2008).

Therefore there is a considerable need for more PSA-specific studies using rigorous methodologies to establish firm conclusions with regards to the comparative effectiveness of ACT with other treatments or alternative modes of delivery (Swain, 2013; Ost, 2008).
In light of these, albeit sparse, successes of ACT for SAD and PSA, it is clear that standard length-of-therapy (ten to eighteen hours) is effective for the treatment of SAD and PSA. It is now important to consider whether ultra-brief (one to three sessions) modalities of ACT would be effective in maintaining positive change using a different mode delivery format.

To date, no study appears to have directly examined the effectiveness of ultra-brief ACT and its brief delivery variations such as self-help and group-format. This is surprising when brief therapies can be as effective as longer term therapies (Strosahl et al., 2012). In the UK, there has been debate over how best to promote recovery and make evidence-based psychological therapies widely available at lower cost (NICE, 2013). Therefore, alternative approaches including the use of more disseminable formats and designed with minimal therapist contact in mind such as self-help or brief group-based interventions clearly warrant exploration in order to assess the feasibility of such an approach. The key advantages of brief-format therapies are (i) lower delivery costs and (ii) dissemination of therapies to large populations including otherwise hard to reach groups including those reluctant to seek assistance. University students are one such group. This group are typically on tight budgets and may have some difficulty in accessing therapist-directed evidence-based interventions. Group interventions offer cost effectiveness, briefer group intervention also can be helpful in creating access opportunities for learning, improved social connection, increased awareness of the collective human experience and offer a means for managing problematic social interactions through opportunities for exposure to feared situations in vivo (Heimberg et al., 1998).

Depending upon one's point of view, the ACT literature to date for SAD and PSA provides either only tentative support for the usefulness of ACT or the hint of a much brighter future. This mixed response is likely because until now studies investigating efficacy of for SAD/PSA have not yet investigated whether ACT can maintain efficacy when delivered in briefer forms for example over two or three sessions. Furthermore no study to date has directly compared the effectiveness of different delivery variations of ultra-brief ACT as a self-help versus group-format intervention. There is preliminary evidence showing that group-format (Johnson, et al, 2016, Block 2002) and self-help interventions of ACT can be effective (Beharry, 2008); therefore, this thesis sets out to examine (i) whether an ultra-brief intervention of ACT can demonstrate sustained efficacy and (ii) investigate whether there are any differences in efficacy and sustainability between the non-guided self-help and the group-led therapy formats.

Chapter 2

Empirical Study

Investigating the effectiveness of Acceptance and Commitment Skills Training with people public speaking anxiety via a randomised controlled trial of group format vs self-help format

ABSTRACT

Public speaking anxiety (PSA) is commonly reported across both student and general populations. It is associated with substantial difficulties across the broad life domain. The prevalence and debilitating impact of PSA/SAD combined with currently limited therapeutic resources, indicate a need for an effective, widely accessible therapy approach. PSA is considered a low priority by health professionals. Therapist-directed treatments can be costly and difficult to access, especially for vulnerable individuals lacking financial resources and often experiencing time constraints. Acceptance & Commitment Therapy has a growing evidence-base for many psychological issues including social anxiety.

Brief-delivery formats offer reduced delivery costs with wider dissemination to a large population. This study compared non-guided self-help and group-led ACT brief-delivery formats to determine if there were differences in efficacy and sustainability. To this end, the study was designed to compare the efficacy of the two styles of briefer ACT interventions for PSA using two groups from a community sample in a randomized controlled trial.

The results of this study demonstrated that ultra-brief ACT interventions have been effective with clients experiencing PSA when delivered either as a self-help format or a group format. It is hoped that the findings of this research will provide additional information and encourage further research in this field. That it will play a valuable role in the use and dissemination of ACT as an alternative intervention in the treatment of PSA and mild social anxiety in both clinical and non-clinical samples.

Key words: Public speaking anxiety, social anxiety, ultra-brief Acceptance and Commitment Therapy, group based versus self-help format

Chapter 2

The Current study

2.1 Study Overview

Fear of public speaking is a typically reported problem by individuals experiencing SAD. People who fear speaking in public may have decreased educational achievement and career opportunities which in turn may lead to great psychological distress and frustration (Aderka, Hofmann, Nickerson, Hermesh, Gilboa- Schechtman, & Marom, 2012; NICE, 2013; Stien et al., 1996). CBT-based treatments have been empirically supported for SAD and more specifically for PSA. However, the results from a small number of studies have reported that existing CBT treatments are not effective for every individual who experiences SAD and PSA (Dalrymple & Herbert, 2007; England et al., 2012). Many researchers have also suggested that traditional cognitive restructuring and viewing of psychological difficulties as the result of faulty thought processes may not be effective in the treatment of social anxiety (Dalrymple & Herbert, 2007; Eifert & Forsyth, 2007).

ACT attempts to increase an individual's acceptance of internal experiences and has demonstrated its effectives across a wide range of psychological issues (Hayes et al., 2006; Power et al., 2009). The results from experimental studies which have applied ACT to difficulties associated with social anxiety seem to be promising with regards to efficacy as indicated by significant improvement in the participants' quality of life, a reduction in their social anxiety symptoms and decrease in behavioural avoidance. However, ACT efficacy studies for SAD/PSA have often neglected to investigate whether ACT retains efficacy when delivered in much briefer forms for example over two to three sessions; also

neglecting to examine whether there are any differences in effectiveness between different delivery modalities such as non-guided self-help versus a group-led therapies format.

Previous studies have lacked in terms of a thorough follow-up evaluation. Follow-up analysis is important since, the immediate effects of therapy can fade over time (Gifford, Kohlenberg, Hayes, Antonuccio, Piasecki, & Rasmussen-Hall, 2004). Therefore further studies will be necessary for examining the effectiveness of different modalities of brief ACT model for the amelioration of SAD/PSA. This will require conducting larger, more extensive trials as well as short interventions, and to follow these up with studies to examine longer-term efficacy.

Further studies addressing the efficacy of ACT in comparison with other empirically supported studies would be beneficial. Studies have frequently suffered from high attrition rates which poses another problem for ACT studies, since it then produces a lower power in statistical analyses. These studies also lack in terms of cultural and ethnic variation having mainly recruited white American female participants. By recruiting larger populations from a range of clinical and non-clinical settings, incorporating more male participants, encouraging participation by reaching out to a variety of ethnic groups and classes would markedly increase the robustness of such a study.

Despite its potential, ACT needs to continue to grow its empirical base in order to properly demonstrate its efficacy. All the aforementioned ACT studies for SAD/PSA represent a preliminary step in providing evidence for the effectiveness of ACT. Results from research has demonstrated that ACT can produce equivalent outcomes when compared with CBT when applied to decrease some negative aspects of social anxiety and rendering cognitive change, yielding moderate to large effect-sizes (Swain et al., 2013).

When investigating the possible merits and disadvantages of potentially efficacious therapies such as ACT, it is essential to include brief-format therapies that are increasingly desirable due to delivery cost, time and access constraints for potential beneficiaries. Thus, trials which examined the different delivery modalities must account for the practical aspects in terms of time-constraints and funding implications.

2.2 Aim of Study

This study is intended to advance previous research in three ways -

(I) To investigate an ultra-brief trial of ACT (by comparing a group format with a self-help format) for university students and staff with PSA; to assess whether brief ACT interventions are effective with regards to increasing psychological flexibility, increasing the participants' willingness to engage in feared situations and increasing valued living.

(II) Utilizing more rigorous methodologies by conducting a randomised controlled trial, recruiting at larger scales.

(III) Conducting a follow-up to assess the long term effectiveness of ACT.

As discussed previously, a university student population was targeted in this study. PSA is very common throughout the general population and for the purpose of this study (arising from time and funding constraints) student participants are considered to be representative of the wider population. Students experiencing SAD or PSA frequently use unhelpful strategies to cope with anxiety (Lopez et al., 2013). This would include avoiding taking lectures that require presentations or to seek alternative "safe" module options where the emphasis is upon providing written coursework rather than having to be assessed by a compulsory oral version of the presentation. In line with this, research has suggested that in

some situations students seem to prefer not to disclose their fear of public speaking and would rather sacrifice any assessment marks by not attending a lecture where they are expected to present (Tillfors & Furmark, 2007). This inevitably creates a significant disadvantage for this student group. In the short term, these avoidance strategies may reduce anxiety but over the longer term it could be a primary factor that leads to an increase in the levels of anxiety, under-achievement and drop-out rates (Tillfors & Furmark, 2007). Hence, this may explain a possible link between SAD, PSA and the lower degree of academic achievement (Tillfors & Furmark, 2007).

2.3 Rationale for the Study

Given the prevalence and debilitating impact of PSA, combined with currently limited therapeutic resources, there is need for development of effective, widely accessible therapeutic approaches and the associated training packages. Therapist-directed treatments can be costly and difficult to access, especially for vulnerable individuals lacking financial resources and often experiencing time constraints. PSA is currently regarded as a low priority by health professionals, thus the time and costs involved for therapist training, supervision and delivery logistics become prohibitive (Yuen, Herbert, Forman, Goetter, Comer, & Bradley, 2010). Moreover, due to restricted funding, time limitations, limited resources and the quality of providers' intervention skills, the development of a standardized-format intervention that is cost effective, readily accessible and time efficient would be greatly beneficial. Despite the aforementioned ACT studies, implemented over the past two decades, there is still much scope for further ACT-centred research and currently, published research on ACT for public speaking anxiety is very limited. For example, to date, there are only a very few studies which have examined the effects of brief intervention versions (6-8 sessions including 12-16 hrs.) for ACT approaches that dealt with

PSA (Block, 2002; England et al., 2012**)**. Furthermore, these studies had high attrition rate which have made it difficult to draw general statements about the effectiveness of ACT interventions; they also lacked an independent evaluator since all data were based on the self-reported fear and willingness rating. Therefore, the participants' self-reporting may have been influenced by social desirability (Block, 2002). These studies would have been strengthened by incorporating measures of directly observable behavioural change. A recent meta-analysis by Cuijpers, Li, Hofmann & Andersson (2010) suggested including both self-help reports and observational measures where possible in order to enhance the efficacy evaluations.

In the light of these previous successes of ACT for SAD and PSA it is important to consider whether different modalities of ultra-brief ACT can maintain positive change in outcomes that are at least as effective as seen for more established therapies. As already stated, given that soaring demands on health care, brief forms of therapies utilising different delivery modalities may be valuable in potentially promoting recovery, reducing healthcare costs and increasing dissemination of therapies to a larger populations.

2.4 Brief Intervention

Brief intervention therapy gained considerable popularity during the 1980s, as longer-term therapy was found to be expensive and inaccessible to the majority of people (Strosahl et al., 2012). Ultra -brief interventions are a relatively new trend and generally considered to be defined as a programme of less than six sessions, arising in response to resource constraints upon psychology services (Shapiro, Barkham, Stiles, Hardly, Rees, Reynolds, & Startup, 2010). Some studies had already found short-term therapy to be as effective as long-term therapy (Hirai & Clum, 2006; Herbert et al, 2005) but with the caveat that brief therapy

may not be suitable for individuals experiencing serious chronic or acute mental health problems (Feltham, 1999). Additionally, the brief approach assumes that the client is willing to consider making cognitive and behavioural changes over a relatively short time-frame. Therefore the clients who are ambivalent or unwilling to make relatively rapid changes may not derive benefit from time-limited therapeutic interventions.

ACT principles have previously been successfully used in brief interventions (Strosahl et al., 2012) and were found to be effective in the treatment of depression (Zettle & Hayes, 2002); panic (Hayes et al., 2012); for social anxiety (Dalrymple & Herbert, 2007).

Controlled trials of ACT (Bach & Hayes, 2002; Block, 2002; England et al., 2012) had established that a benefit could be offered in six to twelve sessions. These studies are encouraging and show that there is potential for offering efficacy even with the briefest of intervention protocols.

Brief therapies can be cost-effective and facilitate the dissemination of therapies to a much wider population of individuals than otherwise possible. In particular, university students are one such group. They frequently lack financial resources or the time to engage with services and may have some other difficulty in accessing therapist-directed, evidence-based interventions. Brief therapies using group designs have been reported to be effective and particularly helpful for individuals with a fear of public speaking for example Cognitive Behavioural Group Therapy (Hope, Herbert, & White, 1995). It is well-recognised that there are benefits to group-treatment over individual psychotherapy. For the individual, these include the opportunity for vicarious learning; increased awareness of the collective human experience; decreased suffering in isolation and help with problematic social interactions by providing opportunities for exposure to a feared situation in vivo (Heimberg, 1998).

2.4.1 Self-help Interventions

Self-help intervention is a pre-planned, low-cost approach designed to help a relatively large number of people with minimal input from a therapist (Strosahl et al., 2012). It is intended to facilitate the administration of a standardized treatment to clients experiencing a variety of mild to moderate mental health problems such as anger, depression and anxiety-related difficulties.

Carefully prepared self-directed therapies have been shown to be able to provide individuals with the means to overcome the perceived obstacles typically associated with one-to-one therapy including financial cost, accessibility and the stigma/embarrassment often associated with seeking help from a professional (Cooper, Coker, & Fleming, 1994; Johnson, 2008).

Self-help interventions have been shown to be useful in the treatment of anxiety and panic problems and have been recommended by NICE 2013 guidelines as one of the initial treatment option for social anxiety up to nine sessions of supported CBT based self -help book (Hirai & Clum, 2006; Main & Scogin, 2003; Johnson, 2008; NICE, 2013).

The Menchola et al (2007) meta-analysis of self-help interventions on depression and anxiety showed that the self-help format provided moderate effect sizes. However, small sample sizes may prevent conclusions being drawn about comparisons between the disorders (Menchola, Arkowitz & Burke, 2007).

The effectiveness of guided self-help over non-guided (without aid of practitioner) has been debated (Hirai & Clum, 2006; Gellatly, Bower, Hennesy, Richards, Gilbody, & Lowell, 2007). Some studies suggested that guided self -help was more effective than then non-guided (Richardson, Richards, & Barkham, 2008) Some critics such as Newman (2008) and

Haeffel (2010) highlighted that self-help interventions may not be suitable for everyone, for example individuals experiencing post-traumatic stress disorder (Wessely et al., 2008). Caution should be exercised when self-help interventions are an option; there should be clinical screening for other mental health issues for which there is no evidence-base to support the use of self-help interventions.

Overall, the ACT literature to date for SAD and PSA provide support for the usefulness of ACT. No study to date has directly compared the effectiveness of different delivery formats of ultra-brief ACT as a self-help vs group intervention. Therefore, the current study is intended to bridge this gap and to evaluate the potential for development of an ultra-brief ACT protocol for sub-clinical public speaking anxiety in a controlled trial. Further, an ultra-brief ACT as a group intervention will be compared to a solitary activity through completion of the self-help workbook intervention. The potential use of brief therapy as a low-cost and easily disseminated therapeutic option underlies the need for more randomised controlled trials.

Therefore, this thesis sets out to examine whether an ultra-brief intervention of ACT can have sustained efficacy and to investigate whether there are any differences in effectiveness and sustainability between the non-guided self-help and group-led therapies format. With appropriate evidence, it is to be hoped that there will be increased interest and to gain further support for ACT and improve therapy outcomes.

2.5 Research Questions

The study was designed to answer several questions, as follows:

(I) Will Acceptance and Commitment Training reduce avoidance and increase psychological flexibility, increase the participants` willingness to engage in feared situations?

(II) Can efficacy be maintained following an ultra-brief Acceptance and Commitment Training session based on ACT intervention with individuals having prior moderate public speaking fear?

(III) If change occurs, is it produced by changes on ACT relevant process measures?

(IV) If change occurs at post-intervention, is it maintained at follow-up?

(V) Is the group format more effective than the self-help format?

(VI) Can ultra-brief self-help interventions create positive outcomes that are similar to group therapy?

2.5.1 Hypotheses

The main purpose of this study was to examine the efficacy of an ACT intervention for PSA when applied to university students and staff with a sub-clinical fear of public speaking. The Acceptance & Commitment-based approach targets avoidance and attempts to increase acceptance and willingness to create change, therefore this current study hypothesised that an ultra-brief acceptance and commitment-based skills training would allow individuals to develop more effective ways to cope with their public speaking anxiety. Based on the literature review presented in chapter one the following hypotheses have been formulated:

Hypothesis 1: It is expected that ACT interventions (both self-help and group based) will have a significant and positive effect on the outcome variables of interest, but that the mode of delivery will have no impact on outcome.

2.6 Methodology

This study employed a quantitative methodology considered appropriate for the aims of the research. A randomised control trial (RCT) was employed to investigate the efficacy of acceptance and commitment training based on ACT. RCT is considered to be one of the most rigorous research methods of evaluating whether a cause-effect relationship exists between an intervention and outcome (Kendal, 2003).There have been a number of studies of the application of ACT as a therapeutic approach which have utilised RCTs to investigate the efficacy of ACT. In those studies, ACT was compared singly or in combination with another treatment (Ost, 2008).

2.6.1 Research Design

In this randomised controlled trial, the participants were randomised when being assigned to the intervention or comparison group (to receive self-help workbook).

The advantages of utilising RCT included: maximization of statistical power, to minimize selection bias and confounding factors (Kendal, 2003). Online block randomisation (http://www.graphpad.com/quickcalcs/index.cfm) system was used to ensure equal sample sizes were assigned to the each intervention.

Independent variables were assigned thus; the intervention modality (between subjects), which was on two levels; an ultra-brief acceptance and commitment training delivered in a group format vs. self-help workbook-format, and ‘time’ (within subjects) referring to base-line, post-intervention, and follow-up.

Outcome variables related to the processes of ACT (AAQ, WILLINGNESS, VALUES, VALUES 34) and presentation of anxiety (PCSR, SIAS) were measured.

2.6.2 Inclusion and Exclusion Criteria

Inclusion criteria

Participants who reported and self-identified as having PSA by responding to the advertisement, completed online screening. Participants who scored thirty-four or below on the Social Interaction Anxiety Scale (SIAS) (Mattick & Clarke, 1998) were invited to participate. This was to prevent the inclusion of individuals with severe social anxiety.

This cut-off score for sub-clinical social anxiety was developed by Mattick & Clarke (1998) and also used by Brown, Turovsky, Heimberg, Juster, Brown & Barlow (1997) and Heimberg et al (1992) in order to distinguish clinical from non-clinical samples.

Exclusion criteria

Persons under eighteen and those who demonstrated evidence of severe social anxiety (scored over thirty-four) were excluded, as determined via on-line screening. Exclusion criteria also included other mental health issues, suicidal potential, presently taking psychiatric medication. All participants were informed about the exclusion criteria and completed on-line screening to establish initial eligibility for the study.

2.6.3 Sampling & Recruitment

Following a favourable opinion from the University of Wolverhampton ethical review, participants were recruited through announcements via a student email database held by the

Students Union of Wolverhampton; the undergraduate psychology participant pool system, and within newsletters to staff. Participants who were interested in taking part were invited to complete an online screening questionnaire, The Social Interaction Anxiety Scale (Mattick & Clarke, 1998).

2.6.4 Social Interaction Anxiety Scale (SIAS)

The SIAS (Mattick & Clarke, 1998) has been used as a screening/baseline questionnaire to assess anxiety level related to social situations. The data obtained from this baseline questionnaire served as a pre-intervention assessment. The SIAS is a 20-item measure for the assessment of general fears of social interaction. Items are rated on a five-point Likert scale (0 = not at all characteristic or true of me to 4 = extremely characteristic or true of me). Item 5, 9, 11 are reversed (0=4, 1=3) in order to assess participants` response validity. Scales are scored by summing the 20 items. Higher scores equal greater levels of social anxiety. Higher scores indicate higher social anxiety. This scale has been demonstrated to have good internal consistency (alpha = .93) and test-retest reliability (alpha = .92; Mattick & Clarke). Validation data for the scale were reported by Heimberg, Mueller, Holt, Hope & Leibowitz, (1992).

The SIAS was used as a screening questionnaire to assess anxiety-level related to social situations. Data from the screening questionnaires served as a pre-intervention assessment. Sixty participants who reported experiencing PSA completed the initial screening. Of the sixty participants, only forty met the criteria for mild social anxiety which was measured by the SIAS. Of those forty, seven declined to participate. Thirty four were randomly assigned to one of the two conditions (self-help work-book format versus group) two participants

dropped out over the course of the intervention. Only participants with a complete data set were entered for analysis.

Research participants were thirty-two students and staff with moderate (sub clinical) public speaking anxiety from the University of Wolverhampton.

There were seven males and twenty-five female participants, age ranged 22-60. (The mean age M= 32.71 *SD*= 9. 94)

The descriptive statistics for the age of the participants in the study is presented in Table-1 below.

		Mean	Std. Error
		32.7188	1.75761
95% Confidence Interval for Mean	Lower Bound	29.1341	
	Upper Bound	36.3034	
5% Trimmed Mean		32.2708	
Median		32	
Variance		98.854	
Std. Deviation		9.94253	
Minimum		20	
Maximum		55	
Range		35	
Interquartile Range		17.5	
Skewness		0.592	0.414
Kurtosis		-0.663	0.809

Table-1. Descriptive statistics for the age of the participants in the study.

2.6.5 Materials and Data Collection Methods

Self-report measures were appropriate for the current study. Measures were obtained at screening, pre-intervention; post-intervention and at a one-month follow-up. The data collected at pre, post and follow-up were matched by assigning code-identifiers to retain anonymity and confidentiality. All outcome measures were administered by the researcher and completed by participants individually. This study used the following measures to collect data**.**

2.6.6 Questionnaires/Measures

The Acceptance and Action Questionnaire revised (II)

This questionnaire was used to test psychological inflexibility/ experiential avoidance and acceptance. The AAQ -II (Bond et al., 2011) is a seven-item measure design to assess individual`s accepting attitude toward negative feelings, experiences and the ability to take action even when feeling uncertain. An example of a typical item is "I am afraid of my feelings". The participants were instructed to rate how true each of the 7 statements was for them by using a 7 point Likert scale ranging from 1=never true to 7 always true. Scales are scored by summing the seven items. Higher scores indicate greater level of psychological inflexibility (experiential avoidance).

Preliminary evidence has indicated that the reliability of the AAQ-II is consistently above the AAQ-I, with a mean alpha coefficient across the six samples of .84 (.78 - .88), and the 3- and 12-month test-retest reliability is .81 and .79, respectively (Bond, Hayes, Baer, Carpenter, Guenole, Orcutt, Waltz & Zettle, 2011).

(Please see Appendix-7 for details)

The Willingness Questionnaire

This questionnaire was created by Wulfert & Block (1998) to be utilised to evaluate the participants' willingness to engage in public speaking situations. This questionnaire is an eight-item scale design to assess to what extent an individual is willing to engage in a wide range of academic public speaking situations for example, raising one's hand to make a comment in a large classroom or seminar room. Participants are instructed to rate how willing they are to engage in each of the public speaking situations using rating on a 1 (completely unwilling) to 10 (completely willing). Scales are scored by summing the 8 items. Higher scores indicate greater level of willingness.

(Please see Appendix-9 for details)

The Valued Living Questionnaires (VLQ) (Wilson, 2002)

This is a two -part self-report questionnaire was designed to assess valued living. This questionnaire was used to test the hypothesis that with the acceptance and commitment training living with values would increase. The first item measures which domain of living an individual chooses to value. This first part consisted of 10 point Likert scale where participants asked to rate each domain according to their own personal sense of importance from 1 (not at all important) to 10 (extremely important).

The second part of the VLQ questionnaire measures how much people engage with their values and gives a direct measure of how consistently people are following the values in their life. Participants are asked to rate how consistent their actions have been with this area of life on a scale from 1 (not at all consistent) to 10 (extremely consistent).

Preliminary evidence has shown that the internal consistency for the consistency scale is 0.75. There is also evidence supporting its test-retest reliability (.90) (Wilson, 2002).

Scales are scored by summing the 10 items each. Higher scores indicate greater level of valued living/consistency with values.

(Please see Appendix-10 for details)

Client Satisfaction Survey

This was designed and implemented to ask clients to rate their satisfaction with the training workshops and self-help booklet. There were 4 questions in this survey to assess the acceptability of the interventions. Participants were asked to rate how satisfied they were with the self- help booklet/group workshops, whether they could recommend this training to others. The aim of this short survey was intended to collect quantitative data and allow participants to make any comments that they wanted to share. An example of a typical item is "The self-booklet was 1=very helpful, 5= very unhelpful".

(Please see Appendix-5 for details)

Personal Report of Confidence as a Speaker Scale (The PRCS-Short Form (Hook, Smith, & Valentiner, 2008)

Personal Report of Confidence as a Speaker (PRCS)—Short Form: (Hook, Smith, & Valentiner, 2008). The PRCS is a twelve-item self-report measure of confidence in public speaking situations. This was utilised to assess participants' PSA responses and level of apprehension when faced with the prospects of speaking in public.

PRCS was developed by Hook et al (2008) and has been reported to have good internal reliability, construct validity, consistency and convergent validity with other public speaking measures (England et al., 2012; Heeren, Ceschi, Valentiner, Dethier, & Philoppot, 2013).

The questionnaire consists of 12 items. Participants were instructed to rate on a 5-point Likert-type scale ranging from 1="Strongly Agree" to 5= "Strongly Disagree."

Scales are scored by summing the 12 items. Higher scores indicates less anxiety confidence in public speaking situations.

(Please see appendix, 14 for details).

2.6.7 Intervention Protocol

A brief ACT protocol for students with moderate PSA was developed by modifying the existing protocols of Hayes et al (1999), Eifert & Forsyth (2007). Modification included focussing the interventions on public speaking; presenting the materials in a condensed fashion and incorporating brief-acceptance and mindfulness training. A manual was produced for the therapist, which was used to ensure consistent delivery across different sessions whilst a self-help work-book was provided for the participants.

Modification to public speaking was informed by the Kocovski, Fleming, & Rector (2009) study protocol for SAD and the theoretical and empirical underpinning offered by the literature reviewed previously in Chapters One (please see, 1.14).

There have been no significant differences in the content of both interventions, participants in both groups learned the same ACT skills in order to address their PSA utilising ACT processes.

The ACT protocol materials were taken from the official ACT website www.contextualscience.org. Permissions were obtained to use the materials, these materials are published under a creative commons license and are made available for research purposes.

(See Appendices 15 & 16 for the trainer's manual and the participant self-help work-book).

2.6.8 Data Collection Procedure

Following screening, as described in the recruitment strategy above, those who meet the screening criteria were contacted to take part in the intervention via email. Participants who agreed to take part were randomly assigned to either an ultra-brief (one-hour weekly over three weeks) group-workshop or provided with a self-help work-book. The randomisation was conducted using online block randomisation. Two participants were not able to attend their assigned group workshop due to work/family commitments thus, they were swapped with other two participants from the self-help work-book group. This adjustment was implemented to prevent the potential disproportionate allocation to one particular group.

This training included: brief-socialization to study and understand public anxiety, with an emphasis on experiential acceptance and mindfulness, cognitive defusion, clarification of values and willingness to engage in feared activities for the sake of living with one's values. The group workshop training exercises involved a conflation of lectures, discussions, reading assignments, exercises and practical assignments. The self-help work-book (forty five pages, divided in three chapters) training involved the same combination of reading assignments, exercises and practice assignments as homework. All participants were also asked to generate a list of opportunities for public speaking practice in their daily lives and to choose one meaningful activity each week as a homework assignment that would move them toward reaching their goals related to their values pertaining to PSA**.**

The participants who were randomly assigned to the workshop-group intervention were asked to attend one-hour workshops which were delivered over three consecutive weeks

(total three hrs) at the university-designated rooms. The groups were designed for approximately for ten to twelve participants at a time.

The participants who were randomly assigned to the self-help work-book were given or emailed the acceptance and commitment skills self-help work-book prepared by the researcher which consisted of the same materials as provided for the group workshops. They were asked to read the material, work through each page at a time, by themselves with no trainer-intervention and were reminded that the time-line would simply be three weeks rather than conforming to a rigid schedule.

The assessments and intervention was conducted by a trainee counselling-psychologist, trained in ACT theory and methods, who had also attended a three-day experiential workshop delivered by the co-founder of ACT, Professor Kelly Wilson. Intervention-delivery was supervised and assessed for fidelity by applied academic psychologists having extensive experience of ACT. The interventions-facilitator used the trainer's manual (see Appendix-9) to assure consistency in delivery.

At the conclusion of the workshop, participants were provided with psycho-educational materials covered within the sessions and which were intended to allow them to practice outside of the session.

The main differences between the self-help workbook and the group workshop intervention were as follows: Group sessions were tape-recorded for the purpose of independent evaluation and supervision to assure that the materials were ACT consistent. Participants in the group were given in vivo exposure by encouraging them to present a five-minute talk to the group. On the other hand, each participant in the self-help work-book group was given the willingness questionnaire to rate their willingness to engage in imagined public speaking

situations rather than direct vivo exposure. Although a behavioural measure of public speaking was taken within the group, no data was collected on it.

(See Appendix-16 for self-help booklet, appendix 15 for trainer`s manual for group)

2.7 Intervention

The ACT interventions were delivered either in a self-help work-book format or a group-format. Participants in the self-help group were given a work-book and asked to study each chapter on a three consecutive weekly basis. Participant in the group-workshops were invited to participate in one-hour (per week) workshops over three consecutive weeks and held on the university campus. The common content for both styles of intervention is as follows:

2.7.1 Group Session-1 & Work-book Chapter-1

The objective of Session-1 (workbook Chapter-1) was to help participants to understand the nature of their experience of PSA and to identify their pre-existing coping strategies previously used to deal with PSA. By doing this, the "Creative Hopelessness" (Hayes et al., 1999) stage is intended to help participants examine the likely futility of their past and current efforts.

The activities within session-1 included asking participants to (a) identify their past and current efforts to manage their PSA; (b) reflect how those strategies have worked in the short term and over the longer term (c) review how experiential avoidance as a key part of their previous coping efforts to control their anxiety have impacted upon their lives and what the cost has been. The notion of acceptance and willingness were introduced as an alternative way to deal with anxiety control and avoidance behaviour. Various ACT

metaphors within experiential exercises have been used to facilitate this process such as the "Quick-sand" metaphor (Hayes & Smith, 2005, see Appendix-15 handout 1) and the "Anxiety tiger" (Eifert & Forsyth, 2007); see Appendix-15 handout 1).

Session-1 also included a value clarification exercise in which participants were invited to explore their core values within their lives and to choose one area in particular that PSA has been a barrier to achieving their goals. This was facilitated through work-sheets and developing a specific plan of action, to achieve their value-directed actions related to amelioration of PSA in areas such as those involving friends, family, other relationships, leisure, career, education, spirituality, health, and community (Eifert & Forsyth, 2007).

2.7.2 Group Session-2 & Work-book Chapter-2

Session-2 & Workbook Chapter-2 expanded on the concepts of acceptance and mindfulness; participants discussed mindfulness as a new way of approaching anxiety-related experiences. Participants were encouraged to observe their private events without judging or suppressing, to let go of the struggle and to embrace their previously avoided experiences. "An acceptance-of anxious feelings" exercise was introduced (Eifert & Forsyth, 2005; see Appendix- 15, handout 2) which invited participants to pay attention to their breathing, to learn to observe and to make space for any unwanted inner experiences coming and going, but without attempting to change or trying to suppress them. Mindfulness and other techniques were introduced to invite participants to make full contact with the present moment and the experience of anxiety, to be open and to make room for the anxious moments by noticing all their aspects, learning to staying with them and observing them drifting by (Harris, 2009). The aim of this exercises was to (a) increase acceptance and create a willingness to experience and tolerate discomfort and (b) strengthen the observation

skill of observing whilst declining to make any strenuous effort of control or suppression responses to rising PSA experiences.

Session-2 also introduced cognitive-defusion (Hayes et al., 1999). This stage consisted of inviting participants to observe their thoughts as just thoughts, not taking them as literal truths and to separate themselves from emergent internal unwanted experiences. Experiential exercise and metaphors have been used to facilitate this process such as "Leaves on a stream" (Harris, 2009; see Appendix- 16, exercise 10). This process aims to help participants to learn to respond to their unwanted inner experiences less literally and to create some distance to their thoughts and feelings whenever they feel to be fused and entangled within their evaluative mind. At this point participants were encouraged to explore their thought content and to make distinctions between the thoughts that served them well and those that did not with regards to valued consistent behaviours (Harris, 2009).

Each session and workbook chapter concluded with a brief review and suggested experiential exercises to be undertaken as practical assignments in order to encourage participants` engagement in valued actions. This was to encourage practice in real situations whereby the distinction between "practice" and actual life experience would become less discernible over time. That any previously perceived solid obstacles to engaging in meaningful public speaking situations with family, groups or work colleagues would become less tangible, a faint memory.

2.7.3 Group Session-3 & Work-book Chapter-3

In the final session (Session-3 and workbook Chapter-3) participants were encouraged to face their PSA through exposure, putting into practice the acceptance and defusion

techniques. This session aimed to provide participants with the opportunity to practise willingness in the presence of their inner experiences related to PSA and to prepare them for challenging moments in day-to-day life when planned or unexpected public speaking activities would trigger emergent anxieties. The aim of the exposure exercise is intended to increase the participants' willingness to confront any planned or unscripted PSA situation rather than fostering extinction of the idea of going through with the activity. It also is intended to generate a greater sense of accomplishment, reward and thus confidence. Any actual anxiety-reduction is clearly a bonus for the individual but it should be borne in mind that it is not a formally-targeted outcome of these exercises.

2.8 Ethical Considerations

Prior to recruitment, ethical approval was gained from the Faculty of Education, Health, and Wellbeing, University of Wolverhampton. The British Psychological Society's ethical recommendations (BPS, 2009) were adhered to throughout this research. Confidentiality was maintained in this study. Only personnel who were involved directly with the study such as the supervisors and examiners were able to have access to materials. However, even then, they were unable to link data to participants as the anonymised data was ID-coded.

Informed consent was obtained. To retain anonymity, all identifying features were concealed by assigning alternate identifiers for participants. The anonymised data was entered into a password protected computer for statistical analysis. All participants were informed that they would be given an opportunity to request a copy of the completed study. All participants were informed that they could withdraw their data up to the point of data analysis without giving any reason.

(See Appendix-2 for the consent form and appendix 3 for the participant information sheet).

2.8.1 Post-study Counselling Advice

The study included individuals who experience mild (sub-clinical) public speaking anxiety. All participants, who scored within the clinical range on the SIAS, received an email providing contact information for anxiety-support organisations. All participants were informed that if they experienced significant worrying symptoms during or after the intervention exercise then the researcher would be able to refer them to Wolverhampton University Student Welfare and counselling services or to advise them to contact their GP. A list was made available which comprised contact details of anxiety helplines and support services such as provided by Anxiety UK, Mind and Samaritans (see appendix 13 for details).

2.9 Results

2.9.1 Demographics

Sixty participant completed the online screening, of those forty were identified for participation. Eight participants dropped out of the study before the study commenced due work/family commitments. Thirty-two agreed to participate in the study. Of those who wished to participate eight participants were university staff and twenty-four participants were under or post-graduate students from a variety of ethnic backgrounds. After data-cleaning for outliers (N= 1), 31 (self-help N= 16 group N=15) remained. There were 24 females, 7 males, their ages ranged from 20 to 60 (The mean age M= 32.71 SD= 9. 94).

2.9.2 Preliminary Data Analysis

The Statistical Package for Social Sciences Analysis of Moment Structures (SPSS/Amos) was used to manage data and conduct the analysis. Prior to data analysis, the data-set was cleaned, and variable values were examined to determine the accuracy of data entry. Missing

data analysis found a number of cases had missing data on the VLQ (VALUES and VALUES 34) questionnaires at the baseline, post-treatment and follow-up measures. Missing data appeared non-random and related to certain questions, which included some delicate topics and life preferences such as spirituality and parenting. It is possible that some questions were not relevant to certain individuals for example those that referred to parenting. To handle these missing data, it was appropriate to calculate mean scores for any completed items on those value questions that had been re-adjusted and averaged. This method was used for all participants with two or fewer missing items on these questionnaires. Syntax was used in SPSS to calculate this mean. This prevented the exclusion of participants due to missing data and who may have a different lifestyle and preferences, for example, those having no children.

The total scores on the outcome variables of interest were screened for outliers and any participants consistently scoring more than two standard-deviations above the mean on outcome measures were excluded (see Appendix-17 for the SPSS output/syntax, outlier screening).

Preliminary analyses confirmed that the experimental groups did not differ on the outcome variables of interest at baseline (a Bonferroni correction was applied to the alpha level for these analyses to account for the use of multiple tests). No significant differences were found between experimental groups at baseline (See appendix, 18 for T tests).

2.9.3 Analysis Plan

The MANOVA will test the hypothesis that; There will be no significant difference between ultra-brief self-help and group-based ACT at post-intervention or at a one month follow-up review of social anxiety, public speaking anxiety, willingness, psychological flexibility and

valued-living, however, that both groups will improve their scores on these measures from baseline.

To test this hypothesis, the effect of the interventions on six outcome-variables were assessed using mixed Multiple Analysis of Variance (MANOVA). There were two independent variables. These were the intervention (group based, or self-help) and the time (baseline, post intervention, follow up). The effect of these variables on six outcome variables (SIAS, Values, Values 34, PCSR, Willingness and AAQ) was tested. Therefore a 2x3 mixed MANOVA was conducted. This was followed by a post hoc analysis on each measure and to contrast each measure between pre, post and one month follow up intervention phases. Alpha was set at $p = <.05$ for all analyses.

2.9.4 Testing MANOVA Assumptions

A preliminary analysis was conducted to test the assumptions of linearity, homogeneity of variance and co-variance, multi-co-linearity and assumptions of independence and random sampling. Data were screened for multivariate outliers. No serious violations were noted.

Power analysis for MANOVA said to be difficult as it always over-states the numbers needed. Thus power analysis was not conducted (Field, 2010).

Normality was assessed by closer examination of the histograms. The spread of scores on AAQ, PRCS appear to be reasonably normally distributed. The spread of the scores in SIAS and Values questionnaires was not normally distributed. However this was expected due to the nature of their data being not typically normally distributed. There has been a ceiling effect with SIAS as there was a threshold; the study excluded participants who scored over the cut-off score of 34.

The data on the Values questionnaires were also not typically distributed, as it was mentioned above it consisted delicate questions in relation to values and valued-living. It was expected that not everyone will value all areas the same thus, it was expected that some questions would be left unanswered or scored high or low depending upon the personal choices. For example, questions about valuing having children or spirituality beliefs may change from person to person.

The assumptions of homogeneity of variances was tested using Levene's test of equality of variance. The result of this indicated that the Levene's test was significant for post-PRCS (.007 < .005) and the follow up AAQ (.044< .005), suggesting that those variables violated the assumption of equality of variance. But this violation was acceptable as MANOVA is a very robust, conservative statistical approach making it unlikely that a significant results would be found by accident (Field, 2010).

2.9.5 Investigation of Overall Multivariate effect

Table-2 below shows the mean scores of the intervention type between groups over time. The mean scores indicate an overall medium multivariate effect of time and intervention on the outcomes variables. Intervention type did not have a significant effect on outcome variables. Self-help intervention was equally effective as group based therapy over time.

Table-2 the mean scores of the intervention type between groups over time.

		Self Help Mean (SD)	Group Mean (SD)	Total Mean (SD)
n		16	16	32
PCRS	Baseline	22.06 (5.38)	23.81 (7.35)	22.93 (6.4)
	Post	28.37 (3.22)	33.93 (8.70)	31.16 (7.04)
	Follow up	29.62 (4.03)	33.5 (7.78)	31.56 (6.41)
Value	Baseline	7.30 (1.27)	6.78 (1.44)	7.04 (1.36)
	Post	7.21 (1.03)	7.39 (1.34)	7.30 (1.18)
	Follow up	7.15 (0.88)	7.48 (1.06)	7.32 (0.97)
SIAS	Baseline	16.37 (8.45)	23.06 (9.96)	19.71 (9.87)
	Post	16 (5.42)	15.18 (7.05)	15.59 (6.21)
	Follow up	15.06 (6.78)	15.56 (7.34)	15.31 (6.96)
Values34	Baseline	6.79 (0.78)	6.32 (1.23)	6.56 (1.04)
	Post	7.01 (1.01)	6.79 (1.34)	6.90 (1.17)
	Follow up	6.66 (1.10)	6.95 (1.08)	6.80 (1.08)
Willingness	Baseline	31 (10.9)	32.75 (14.9)	31.87 (12.9)
	Post	38.56 (11.6)	52.62 (11.1)	45.59 (13.3)
	Follow up	45.68 (7.47)	53.62 (10.5)	49.65 (9.85)
AAQ	Baseline	27.56 (6.87)	27.06 (9.55)	27.31 (8.19)
	Post	21.12 (4.16)	20.18 (8.46)	20.65 (6.57)
	Follow up	19.06 (2.90)	19.31 (5.68)	19.18 (4.44)

The results indicated that there was an overall medium multivariate effect of time and intervention on the outcomes variables was significant. Pillai's Trace V= .617, F (12, 18) = 242, p =.04. η2=.617 indicating medium effect size. This main significant effect emanated from within the subject variable of time; Pillai's Trace V= .875, F (12, 18) = 10.502, p = .000 η2= .875 indicating high effect size.

The IV describing intervention type did not have a significant effect on outcome variables (Pillai's Trace V= .326, F (6, 24) = 1.931, p = .117η2 = .326 indicating low effect size.
The results support the hypothesis that there will be no significant difference in the effectiveness of ACT between two groups. The results show that the self-help intervention was equally effective as group intervention.

2.9.6 Univariate Analysis

The significant multivariate effect of time was further explored; with a view to investigating which outcome variables demonstrated overall improvement over time.
Overtime, positive changes were observed in public speaking anxiety, (PSA: F (1.6, 47) = 43, 5 p=.00 η2=0.6), experiential avoidance (AAQ: F (1. 67, 48. 4) = 49. 3p=.00η2=0.6), willingness to engage in public speaking (Willingness: F (1.7, 49) = 56.4 p=.00 η2=0.6 Social Anxiety (SIAS: F (1.4, 43.2) = 5.40 p=.00η2=0.1), and valued living/committed action (Values 34): F (1.8, 54) = 3.82 p= .02η2= .1). With the exception of experiential avoidance and willingness (which continued improving), there was a trend for these outcomes to improve between baseline and post –intervention, but remain stable at follow up. There was no significant change in values clarification (Values: F (1.8, 53) =1. 85 p= 0.16 η2= .06).

The results support Hypothesis that ACT related outcomes changed positively over the intervention period.

2.9.7 Post Hoc Analysis

Post hoc analyses explored the effect of the interaction between time and intervention on individual outcome variables. With regard to the interaction between time and intervention there was no significant effect of the interaction on values and willingness. A close examination of the interaction plots illustrated a trend whereby a slight increase in willingness, and committed action was observed for the group condition over time when compared to the self-help condition (see Figure-3 for willingness; see Figure-4 for values). This observed trend may indicate the potential impact of exposure/behavioural task within the group condition.

Table-3 below shows a slight pattern of interaction between time and intervention for Willingness, between self-help and group over time. This indicates that willingness has slightly increased more in the group.

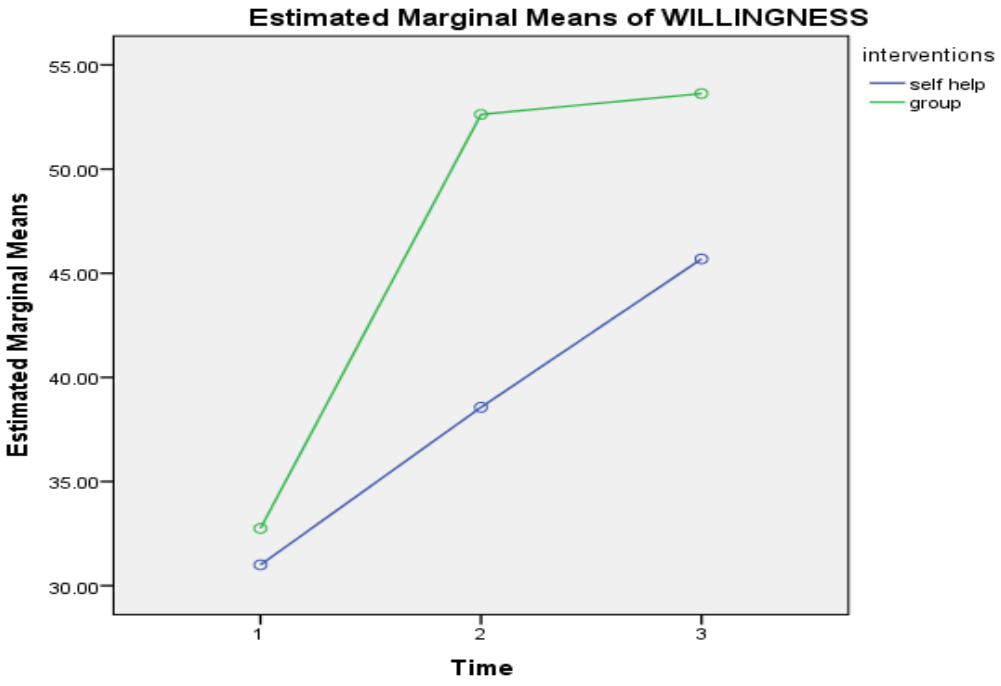
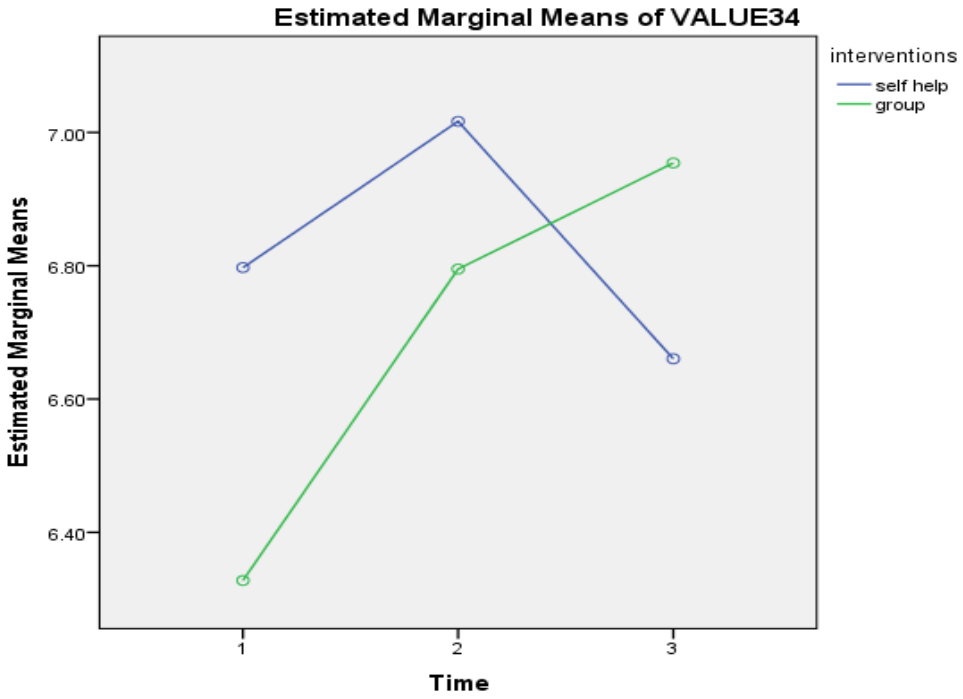


Table-4 below shows a slight pattern of interaction between time and intervention for valued living committed action between self- help and group over time. This indicates that valued living/committed action has slightly increased more in the group. This is may be due to the values and willingness having been more encouraged and promoted in the group workshops and also may indicate the potential impact of exposure/behavioural task within the group condition. Making commitments in social context may also have reinforced and strengthen the action and motivation of the participants.



There was no significant effect of the interaction on the outcome variables of psychological flexibility, PSA and social anxiety. This means that the improvements in psychological flexibility and public speaking/social anxiety within both groups across the three one-hour periods remained the same.

In the main, these results support the hypothesis indicating that (i) the self-help interventions were as effective as the group intervention and (ii) there was general improvement in outcome variables over time.

2.10 Discussion

This study investigated the effectiveness of an ultra-brief ACT-intervention and compared two intervention types (self-help format versus group format) for undergraduate students and university staff who had reported experiencing PSA.

It was predicted that (I) An ultra-brief ACT-intervention (3hrs) would increase psychological flexibility (decrease experiential-avoidance and inflexibility), increase willingness, valued living and committed action; that (II) both modes of delivery (self-help workbook and group-workshop) would be equally as effective; (III) positive change would be maintained and observed during a one month follow-up period. Additionally, it was predicted that the ACT intervention would help to promote a higher threshold before any presentation of symptoms of anxiety. Although the latter is not a specific aim of ACT, it was included because the evaluation of symptom reduction is a widely accepted measure of therapy efficacy (NICE, 2013; Stevenson, 2001).

The results of this study show that the ultra-brief ACT interventions have been effective for people with PSA and mild social anxiety. Outcome and process of change provide support for ACT-related processes. In particular, statistically significant improvements with medium to large effect sizes were demonstrated for participants' psychological flexibility, willingness to engage in previously feared public speaking situations and taking committed actions towards valued living. Intervention type did not have a significant effect on outcome

variables. The self-help workbook format was comparable to the group-workshop format. This indicates that both intervention formats were equally effective.

Consistent with the goals of ACT, brief ACT-based interventions evidenced significant improvements in reported willingness and psychological flexibility together with a significant reduction in mild social anxiety and PSA-measures (PCRS and SIAS). While reduction in PSA was not a particular target, or a hypothesis of the study-interventions, it was not surprising to see a statistically significant decrease in reported PSA and social anxiety as a by-product. On one month follow-up, a further improvement in willingness was exhibited, and a decrease in PSA. Reduction in social anxiety and psychological flexibility (experiential avoidance) remained stable between post-intervention and follow-up.

With regards to willingness-measure, similar results have been seen in the Block & Wulfert (2002) study which found an increase in reported willingness to engage in public speaking activities as measured by use of the same willingness questionnaire developed by Block & Wulfert (2000).

The results are consistent with Ossman et al (2006) who found significant decreases in the symptoms of social phobia and experiential avoidance measures and found an increase engagement in life values between post-treatment and follow-up measures. However the Ossman (2009) et al study used only a group format intervention containing ten sessions spread over three months. This study used similar outcome measures such as AAQ and VLQ, however social anxiety was determined using other measures such as SPAI (Social Phobia and Anxiety Inventory, Turner, Beidel, & Dancu, 1996). Given the brevity of this current study, the results are promising, to be able to see how even a brief-form intervention can produce a significance difference.

There was no significant difference between groups in the rate of change over time, however upon closer examination, those participants who had attended the group workshops reported a slightly higher willingness to engage in feared public-speaking situations together with a higher score for both valued living and committed action. This is may be due to inclusion of the exposure elements in the group sessions where participants were given an opportunity to speak and engage in discussions within a group during the intervention; the value components pertaining to public speaking having been more actively encouraged and promoted during the group workshops. This finding supports England et al (2012) who found six hours of acceptance-based exposure therapy in a group setting more effective than traditional exposure for reducing public speaking fear as measured by PRCS. The results also supports the Dalrymple & Herbert (2007) study which revealed that the ACT-based exposure treatment produced significant improvement from pre-treatment to follow up on self-report measures of SAD symptoms.

The implications of these results suggest that acceptance based exposure elements appear to play a role in creating psychological flexibility to deal with difficulties pertaining to a fear of public speaking. Therefore future studies might wish to design ultra-brief acceptance-based exposure exercises to either use within their treatment context or to compare effectiveness with established therapies e.g. CBT, exposure therapy.

With regard to values, clarification of values slightly increased pre- to post-intervention and this change was maintained, continuing at the follow up. Committed action toward valued living also increased over time and there was a significant change from pre to post. This suggests that the ultra-brief intervention may be sufficient to create significant difference within a relatively short period. Given that valued living is posited as a primary process of

ACT, the results of this present study are promising (Wilson, Sandoz, Kitchens, & Roberts, 2010).

Value clarification/committed action towards valued living is one of the core ACT processes which aims to enhance quality of life. However it seems to have received very little attention to date. It is surprising given that it is one of the key indicator of improvement within ACT model and process (Wilson, Sandoz, Kitchens & Roberts, 2010). This present study supports the idea that values-based living may play a role in creating positive outcome for individuals with PSA, therefore the potential role of value clarification and valued living in psychotherapy deserves further investigation.

The current study results are consistent with the Ossman et al (2006) and Dalrymple & Herbert (2007) studies which had found improved quality of life and increased engagement in living more closely aligned with values. However, it should be noted that these studies used longer treatment times for a clinical sample experiencing generalised SAD.

Overall, the findings for this present study are consistent with previous research such as England et al (2012), Block (2002) and Ossman et al (2006) that had indicated ACT-interventions were effective in the treatment of PSA.

The findings of this study are the first to suggest that an ultra-brief self-help format employing an ACT-style intervention can be highly effective in creating a positive change in the ACT-relevant processes, such as psychological flexibility, willingness, acceptance and valued living in the context of dealing with difficulties associated with PSA. Alongside this, the finding that the self-help format was comparable in efficacy to the group-intervention suggests that the self-help format can be a highly effective mode of delivery

which has the potential to increase availability and affordability of evidence-based interventions.

Both findings have significant implications for practice, such as reducing the implementation cost and reducing the need for therapist contact. Given the high prevalence of PSA and costly long-term effects on individuals, such as occupational and academic functioning (Dalrymple & Herbert, 2007). These results hold real potential for application to practice with this population.

The findings are consistent with a study conducted by Beharry (2008), who found a significant decrease in SAD and PSA measures, a decrease in experiential avoidance and an increase in reported quality of life. That being said, the Beharry (2008) study incorporated therapist contact and did not use a brief format. The Beharry (2008) self-help book comprised nine components whereas the self-help booklet in this present study included only three components. Overall the Beharry (2008) data suggested that the use of a self-help book together with regular therapist contact had increased self-reported willingness to approach public-speaking situations and had decreased self-reported avoidance of these situations. Again given the brevity of this present study the results are promising that even a brief-format self-help intervention without any therapist involvement can also be effective in the alleviation of PSA and mild SAD.

Within the current study, the effectiveness of both modes of ultra-brief intervention appeared to be the result of changes that are emphasized within ACT processes (Hexaflex). The ACT-based interventions in this present study have produced significant improvements in measures consistent with ACT such as psychological flexibility (AAQ-II Acceptance and Action Questionnaire, Bond et al., 2011) and values which was evidenced by self-reported

increased values-based activities (VLQ, Wilson) related to PSA. As discussed (see, 1.13) psychological inflexibility and experiential avoidance are the main characteristics of anxiety-related difficulties (DSM-IV; Herbert & Cardaciotto 2005; NICE, 2013) Here, individuals show unwillingness to remain in contact with their unhelpful and unwanted inner experiences, using avoidant coping strategies to alleviate distress (Hayes et al., 1999). The ACT intervention targets psychological inflexibility and experiential avoidance by actively encouraging people to accept the presence of, and to allow space for unwanted thoughts, feelings and physical sensations without avoidance, to focus instead upon behavioural change toward a consistent valued direction. This means accepting the experience of otherwise typically unwanted emotions such as anxiety or distress (Hayes et al., 1999). The therapy does not try to reduce the distress or anxiety that is linked to these behaviours but instead it aims to increase the willingness to engage in valued activities and to decrease avoidance behaviour (Harris, 2009). Consistent with ACT good practice, the participants in both groups learned to observe their internal experiences as natural, transient events (Hayes et al., 1999) and to accept their unwanted experiences related to PSA in the service of value guided living and not in the service of experiential avoidance.

Overall, the hypothesis in this study was supported and the outcomes have provided consistent evidence for the effectiveness of ACT in creating psychological flexibility to help clients who experience moderate PSA and mild SAD. The findings are highly promising given the brevity of the interventions and provide useful additional data on the utility of ACT as an alternative intervention for PSA.

2.11 Evaluation, limitations and directions for future research

This present study has endeavoured to address methodological limitations that were highlighted by Ost (2008). This was achieved by using a rigorous experimental design and methodology including randomized assignment to intervention, as well as use of standardised assessment; standardised treatment protocol; supervision; audio recording and including an active comparison group. The method of statistical analysis in the current study was highly appropriate for the research questions addressed. The outcome measures were carefully chosen and have been previously found to be valid and reliable (e. g. Block & Wulfert (2002). Sessions were recorded in order to be checked for consistency.

This study recruited a community sample comprising a broad range of age and social backgrounds. With regard to gender, the use of predominantly female participant may reduce generalizability to the wider population, however given that females are more likely to report PSA (Stein & Gorman, 2001) this was not considered to be overly problematic. Further, these findings are considered broadly applicable to the general population (in work/study or seeking work/study) because predominantly university students were used as a sample in this study and they are typically likely to have PSA due to the pressures of preparing assessments and delivering presentations. Therefore the sample are generalizable to the working-age community. Although a community sample was targeted in this present study, the generalizability of these results to a clinical sample of individuals with PSA is yet to be established.

Feedback received from the participants was positive and they reported finding the ACT style and associated materials to be helpful. Only seven participants provided feedback. Due to the relatively small number of feedback returns, feedback responses were not included in the analysis. Future studies may wish to consider how best to maximise feedback response.

With respect to intervention compliance, most of the participants were able to attend the workshops and complete the self-help workbook.

A positive observation from the research was that attrition was very low when compared to similar SAD studies such as Ossman et al (2006) and Kocovski et al (2009). This may be due to the brief duration of the therapy being popular with participants who had busy lives. This is also consistent with a study conducted Dalrymple & Herbert, (2007) suggesting that a brief-format therapy can be more effective than the extended therapy in the treatment of social anxiety and has the benefit of attracting a lower attrition rate. Other factors that may have contributed to the low drop-out may have included aspects of the participants' personal characteristics such as their initial level of motivation, willingness to change and overcome their difficulties. Also, the mode of delivery in terms of the quality of the materials employed could well have played a part. This has ramifications for future studies in terms of taking into account the quality of presentation materials deployed such as images (both still and video), presentation slides, metaphors style, discussion content and exercises. In line with this, a meta-analysis by Swift, Greenberg, & Roger (2012) had found a premature discontinuation associated with study-participants' age, therapy effectiveness/ design settings and the nature of the therapeutic relationship.

It could be argued that a limitation of this present study was the lack of a control group. Participants may therefore have improved without any therapeutic intervention. A control group is essential at some stage in the research process for the proper development of a robust methodology. A control group would provide much-needed base-line data and allow a comparative assessment of findings (Goodwin, 2010). Lack of a control group during the early stages where the primary aim is to assess feasibility, should not be a problem provided that later work incorporates a control group to enhance the robustness of ongoing research.

For example, lack of a control group could hinder the researcher`s ability to evaluate truly whether time alone, rather than the intervention is associated with any gains in the outcome measures. However, the primary aim of this study was to compare the effectiveness of ultra-brief interventions by employing different delivery modes. Including active therapies is said to work better when compared to control groups (Goodwin, 2010). Therefore it was decided that at this stage, the work undertaken was akin to a feasibility study and thus a control group was not essential at this stage in the research process. In addition, the inclusion of baseline screening measures enabled the researcher to compare differences in participants that occurred over time; thus it was considered that the lack of a discrete control group did not undermine the stringency of the study. Some critics argue that a control group is not always necessary as assembling a control group is difficult and it is never truly a control as treatment expectations of participants may influence their responses and therefore it would be unethical to not treat them at all. Additionally, participating individuals' sensitivities may be such that a delayed intervention might cause harm if they feel left out or rejected (Goodwin, 2010).

Future research should include a "no-treatment-control" group to determine whether or not, in the absence of intervention, simply time alone would impact upon the outcome measures. It should be noted that for ethical reasons, resources should be in place to support those assigned to the control group so that they might be offered help after the study terminated.

This study predominantly relied on self-report measures of outcome. Self-report-measures are often used for research purposes and considered to be highly appropriate for measuring psychological constructs such as psychological flexibility, cognitive appraisal and avoidance (Stevenson, 2001). The use of self-report measures may be subject to potential bias such as a social desirability effect or a misunderstanding of the questions. In this study

there was a behavioural task where participants in the group format presented a talk observed by the researcher and the audience, however, there has been no formal behavioural task measures or formal clinicians' rating scale to compare self-reported outcome measures. Such observations were not feasible given the practical realities of this study. Future studies might wish to add measures of directly observable behavioural change and clinician rated scales to compare with the self-report measures. Cuijpers et al., (2010) conducted a meta-analysis examining the effect of psychotherapy on depression including studies using self-report and clinician rated instruments. They found inequivalent results in outcome measures and suggested that particularly in clinical trials it is best to include both measures to evaluate efficacy. In view of the likelihood that participants with PSA may under-report their difficulties, the inclusion of clinician/observer ratings would enhance the robustness of the study. To mitigate any concerns pertaining to limitations in self-report-measures, future research would benefit from including an independent evaluator and clinicians rating to minimize potential biases and make comparisons.

Another limitation of the study was the lack of any assessment measure such as a quiz to assess knowledge of the content and to see whether participants had actually properly read through the content, that they had full comprehension of the content and had properly utilised the materials. Future research should include a quiz and add a measure of goals attainment to evaluate whether participants has been taking public speaking opportunities as they were encouraged. Additionally, future studies may benefit from including focus group interviews which would enable insights to be gained during discussion about the participants` understanding, their attitudes and experiences of utilising the ACT skills.

Resourcing limitations for this study necessitated the use of a time-limited follow-up assessment which is intended to adequately demonstrate the effectiveness of ACT at a one-

month follow-up. However, a one-month follow-up for this type of study might be considered by some to be too short a follow-up reassessment period (Eifert & Forsyth 2005; Swift et al., 2012). It was not within the scope of the present study to have a longer follow up period, due to the time constraints involved in completing the doctoral research. However to increase the robustness of future research, it may be beneficial to use a longer period before follow-up, in order to better assess longer-term efficacy.

Although this study did not conduct mediational analysis, it may still provide support for the ACT model as the AAQ measure has been used as a general measure of several ACT components which are said to complement each other in creating the necessary psychological flexibility needed to deal with difficulties such as anxiety (Hayes, et al., 2006). The results are promising in that both the group and self-help intervention have been effective in accord with ACT process measures and anxiety measures. Future studies might wish to investigate how the increase in psychological flexibility and valued living or other components such as cognitive defusion, exposure relate to PSA. Also, this study used AAQ II (Bond et al., 2011) which is an overarching and extent measure of psychological flexibility and experiential avoidance, however there have recently been new versions of AAQ developed that are designed for populations with specific difficulties. Thus, future studies might wish to use specific AAQ measures for severe social anxiety such as SA-AAQ (Kocovski et al., 2013).

On a final note, acceptance based exposure elements appeared to play a role in increasing willingness and values based living. This indicates that more research is required in order to understand what the mechanisms of change are that lie behind ACT interventions and what it is within the ACT approach that actually does bring about that change.

2.12 Implications for research and clinical practice

The current study has provided an in-depth exploration of the theory and research related to the effect of an ACT intervention on PSA. The result of the study supports the applicability of brief ACT interventions for individuals with PSA in community samples. Given the high prevalence and debilitating impact of PSA in the general population and among university students (England et al., 2012, Lopez et al., 2013), this study shows potential for successful application of ACT interventions for this population.

Moreover, the findings suggest that brief ACT either as a self-help or group workshop format may be used as an alternative intervention in its own right for PSA, rather than being used as an adjunct to therapist-delivered care. However future studies may be necessary to expand on the findings.

Therapist-directed treatments such as ACT or CBT can be costly and difficult to access, especially for individuals such as university students, who may lack financial resources and struggle with time constrains. As discussed previously, factors supporting the potential use of the ACT self-help format can be cost-effectiveness, accessibility, and ease of dissemination to a broad variety of people with minimal input from the therapist. The use of self-help materials will also overcome some of the obstacles linked to seeking professional help, such as stigma (Hirai & Clum, 2006), and the practicalities of attending clinics whilst working full-time or living in a remote location.

This study suggests that ACT is a viable treatment for mild SAD and moderate PSA. The findings of this study provide initial support for the recognition of brief-format ACT as a preferred therapy for PSA and SAD falling within NICE guidelines. The development of guidelines is based on a robust evidence-base to which this study has contributed a

favourable outcome for ACT as an intervention for PSA. Presently, recommendations within the NICE guidelines only include traditional CBT with 10-12 sessions and now perhaps this can be extended to other forms of evidence-based therapies such as brief ACT interventions both in group and non-guided self-help format can offer an alternative viable perspective in the treatment of PSA and mild social anxiety to complement existing therapies. Brief ACT can also be applicable for use in early intervention settings including the Improving Access to Psychological Services (IAPS) programme. This is because it has good potential to assist recovery and prevent relapse through promoting psychological flexibility and value- based behavioural change, mindfulness and acceptance, (Morris & Oliver, 2009).

As discussed previously, individuals experiencing PSA typically go unnoticed by professionals and such individuals will often under-report (Stien, Walker, & Forde, 1996) which means their unhelpful experiences can exacerbate quickly and they may go on to experience long-lasting impacts on their personal, social and occupational functioning (Stien et al., 1996). Ultra-brief ACT for PSA has potential applications within the occupational and educational sectors. Here, such a brief intervention could be incorporated into employee CPD programmes or university skills development programs designed to address PSA.

The counselling psychologist plays a significant role in developing service provision and health policies. Given the increasing demands on public health services and constraints upon resources, the counselling psychologist may take a lead in the development and delivery of ACT-based brief-format programs in clinical, occupational and academic settings. In addition to serving the wider public, the brief-format approach is just as applicable to clients, clients' families & carers; also applicable within their professional team. Here, it is through

multi-disciplinary team-working which is a key aspect of counselling psychology in clinical practice that the promotion of best-practice approaches to client difficulties can occur, linking current theory, research and practice (Health Care Professions Council, (HCPC) 2013, Standards of proficiency for psychologists). ACT readily lends itself to professional development in respect of self-care and training context (Harris, 2009). Through existing team-development meetings, the counselling psychologists can employ brief-format ACT to help other health care professionals and other clinical staff with their own self-care and that of their clients. To be able to help to manage their difficulties in a new, readily accessible way, to engage with life-issues in a more valued-based way. It could be argued this is pure speculation but it is not the intention to offer ACT as panacea for all of life's problems but it is worthwhile to note it is applicable within many contexts (Ruiz, 2010) and has real potential to treat PSA and social anxiety in many different settings. The potential benefits are so great that it has to be worth further serious investigation with appropriate funding.

Future research, likely including a wide range of working-age adults from a variety of social backgrounds, not just simply utilizing a readily-accessible student sample, would be beneficial. Working-age adults are under ever-increasing pressure to develop good communications skills in an extremely difficult economic climate where performance-anxiety can have serious mental health impacts and long-term consequences. These concerns thus warrant further work with this sample group. It is also possible that the results of this current study can be extended to clinical populations who are experiencing severe social anxiety difficulties.

One potentially interesting area of further research would include "under-represented groups" such as older adults and young people (Swain et al., 2013, p.976). Both of these

groups may well benefit from using technological advances to easily disseminate an ACT-based programme. For example the use of a virtual internet-based ultra-brief ACT-intervention might be deployed and compared with empirically established treatments such as internet-based CBT (Ost, 2008). Given that in this study the effect-impact of the self-help materials was the equivalent of the therapist-delivered workshops, the next logical step would be to evaluate whether the self-help materials could be delivered via another platform, for example on-line, or within a smartphone application. This would further increase the dissemination of the therapy. However, there may be concerns over a perceived or real lack of technology "user-friendliness" with older adults which would need careful thought.

In conclusion, this study represents a small-scale implementation of an ultra-brief ACT-intervention, however, given that moderate to high effect-sizes were gained and maintained at the follow-up, this is a promising area for further research to consolidate the findings. It would appear to have realistic potential application to vulnerable groups such as students who frequently encounter public speaking. As previously highlighted, due to under-reporting, it is quite common for social anxiety symptoms to be missed or ignored by professionals. Over a relatively short period of time, symptoms may exacerbate, potentially with long-lasting effects for the individual. By providing easily accessible community-based interventions this study makes such interventions more accessible to otherwise hard to reach groups in society.

2.13 Summary

Overall the findings that are derived from this study are considered to be methodologically sound, that is, in the use of a standardised assessment; standardised treatment protocol; supervision; audio recording and a randomised controlled trial. It is suggested that an ultra-

brief form of ACT-intervention, even when delivered in two dissimilar formats (self-help versus group) can be equally helpful in creating psychological flexibility to deal with difficulties associated with PSA and mild social anxiety. The benefits were sustained at the one-month follow-up. Because the interventions did present strategies and skills applicable to a wide range of feared situations, a longer-term follow-up assessment may identify further gains due to improvements in ACT processes. As Hayes et al (2006) suggested, an increase in psychological flexibility may lead to improvements in overall psychological wellbeing (Hayes et al., 2006).

This study has provided support for the notion that psychological flexibility (acceptance and reduced experiential avoidance) and valued living is effective in promoting positive change for people with PSA and moderate social anxiety. The results were consistent with previous research conducted by Kocovski, Fleming, & Rector, (2013); Dalrymple & Herbert (2007); Beharry, (2008); Block (2002); England et al (2012) and Ossman et al (2006). Further research would be useful in order to expand on the findings above and to assess whether the results can be applicable and transferable to particular settings before this intervention can be routinely recommended by NICE guidelines.

Chapter 3 Critical Appraisal

The following is a reflective account.

3.1 Critical Appraisal

Within this chapter I reflect upon both my training in counselling psychology and the doctoral research process. Here I discuss my journey toward becoming an experienced counselling psychologist, my current perspective of the profession and how I might continue to grow, not only as I progress toward becoming the counselling psychologist that I have always envisaged becoming upon qualification, but how best to strive to continue that growth and refinement as I progress along my chosen path.

3.1.1. On becoming a counselling psychologist and researcher

In this review I draw upon the ideas that I had developed prior to gaining a training place, discuss improvements in these ideas, and outline the experiences that facilitated my transition throughout the duration of the training. To illustrate these developments, I will incorporate elements of literature and my own reflective journals. With this, I aim to demonstrate the scientist- reflective practitioner stance required in practice as a counselling psychologist (Corrie & Callahan, 2000; BPS, 2009).

3.1.2 Deciding to train in counselling psychology

One of the key factors in my decision to take up counselling psychology training arose from my work as an assistant psychologist and support worker in an acute in-patient setting where, as I saw it, the hegemony of the established medical model was conspicuous. I had first-hand experience of working with people with severe and enduring psychological

problems and observed the negative effects of medicalization typically leading to a power imbalance, social exclusion and stigmatization. Those experiences made me think that there must be better alternatives. Thus I decided to "think outside of the box" and take into consideration the social construction on diagnosis and to question the dominant ideation of the medical model framework and its powerful influence over clinicians to maintain the status quo. I have always had a keen interest in social issues around the welfare of oppressed and marginalized populations and I do believe that psychology has an important role in promoting egalitarianism and social justice, to reduce bias and discrimination in society. Whilst attending a BPS Psychology Annual Conference, an initial encounter with the world of counselling psychology suggested it might be somewhat different to other applied psychology disciplines.

Upon further exploration I realized that the ethos of counselling psychology aligned comfortably with my own sense of social justice and my aspirations to make a positive difference. I find the philosophical underpinning of counselling psychology inspirational for a number of reasons: (i) it builds upon the humanistic value base (ii) places emphasis on the egalitarian therapeutic relationship (iii) respects clients' subjective meanings & experiences and (iv)its positioning as an opponent of the medical model, challenging the pervasive and reductionist categorizations of psychopathology.

3.1.3 Counselling psychology practice and the role of research

Counselling psychologists are considered to be integrative practitioners meaning we are trained to integrate different therapies (such as psychodynamic, cognitive behavioural, systemic, humanistic) to help our clients. This integrative way helps us to work flexibly and broadly by conflating personal factors with wider societal influences therefore a number of

different aspects such as cognitive, emotional and behavioural aspects are assessed alongside the socio-political, socio-economic and cultural contexts. As mentioned above, the counselling psychology profession is rooted within a broad humanistic and existential-phenomenological philosophy which seeks to enhance the understanding of human subjective experiences and meanings whilst maintaining adherence to critical, evidence-based inquiry (Woolfe, 2012).

Research activity is an essential part of our training and clinical practice (Woolfe, 2012; BPS, 2009, BPS, Code of Human Research Ethics, 2014). It is our ethical responsibility to keep ourselves continuously abreast of new developments and endeavour to disseminate research findings into our clinical work to maximize clients` wellbeing (BPS, 2009, BPS, 2014). There has until recently been relatively little interest for research funding involving practitioner psychologists but given the current political and economic climate within the NHS, counselling psychologists are now being trained to develop high levels of competencies within skills such as leadership, supervision, consultancy and teaching/training/research alongside their daily work with clients. This renders them much more employable and adaptable within the current difficult economic climate (Cooper, 2008).

Whilst there are always pressures upon my time, I personally value any opportunities to broaden my skill-set. There are clear benefits to being both researcher and practitioner, the scientist - reflective stance encourages me to employ the latest evidence based knowledge to guide my clinical practice whilst using clinical experience to guide the future research (BPS, 2014).

3.1.4 Developing research ideas and my interest in ACT

My research aspirations and ideas were born from my own clinical practice and personal experiences. During my first year placement, I was introduced to ACT in my supervision session and immediately it resonated with me. I began to explore and find out more about this approach. At the time I was training in CBT and felt that something was lacking. Especially with clients who were experiencing difficulties tolerating their distress and managing their overwhelming emotions. Additionally, feedback from a number of clients suggested that some parts of thoughts-modification appeared to be invalidating their experiences. The more I read about the new approach the more interested I became in ACT. After utilizing ACT in my clinical practice with clients, I felt that ACT did indeed offer greater flexibility and creativity than with other therapies that I been trained to use.

The ACT model sits easily and harmoniously with the philosophy and values underpinning counselling psychology. ACT is a trans-diagnostic approach, which looks beyond the symptoms and diagnostic clarification systems, emphasizing the normality and universality of human distress (Larson, Brooks & Del Loewenthal, 2012, Hayes et al., 1996). In this respect ACT has a huge potential to counter both institutional bias and stigmatization within family settings, communities and wider society by promoting tolerance, acceptance, a non-judgmental stance toward internal and external experiences. Ideally, this may serve to enhance social justice through unconditional acceptance, by celebrating diversity and thus creating rich meaningful and value-based human life (Hayes, 2004). In line with this view a number of empirical studies have demonstrated ACT`s success in reducing bias toward people with psychological disorders (Masuda et al., 2004), also reducing bias toward ethnic minorities in USA (Lillis & Hayes, 2007).

Stigmatization is still wide spread in our society so counselling psychologists should take an important role in reducing stigmatization; ACT offers a viable alternative route to achieving this, by applying ACT skills appropriately with their clients and also by training other professionals to employ the basic concepts and skills needed including cognitive defusion, acceptance and mindfulness. Ultimately, to encourage clients to see themselves and their place in the world differently through helping them to relate their experiences differently and engage in more valued living. Thus, the quality of the therapeutic relationship continues to be important within ACT. It is based on a collaborative and egalitarian relationship which also consistent with the values of counselling psychology (Milton, 2011).

On a personal level, I have chosen to focus upon ACT as a core intervention in my research because I found that I could relate its philosophy with regard to my own private life. This has given me the confidence to apply ACT where appropriate throughout my doctoral training. I have employed ACT with clients of all ages (children, adults & later-life adults) who were experiencing a variety of difficulties and including those having learning disabilities. In my experience, ACT has shown itself to be adaptable, meeting the needs of a wide range of individuals having a variety of different issues. Further, the ACT community has been very generous and creative, having launched a website which is a useful platform for discourse and opinion of evidence-based treatment protocols and guidelines; also for the provision and sharing of comprehensive materials.

3.1.5 Challenges and research on public speaking

There have been some challenges to gaining a more in-depth understanding of the theory that underpins ACT. Initially I found it difficult to understand the derivation of certain

conceptual models especially the concept of Relational Frame Theory (Hayes et al., 2001). At times it felt as if I was "running out of steam" as my potential reading-list seemed to expand before my eyes without any sense of there being a satisfactory conclusion within sight or grasp. However, by attending in continued professional development (CFD) workshops and persevering with further reading I felt more able to get my head around the basic ideas. Eventually, at some point within the most arduous literature review that I had ever attempted, there came the realization that there appeared to be little research upon the potential efficacy of ACT for the amelioration of public-speaking-anxiety (PSA). As a sub-set of generalized-social-anxiety-disorder, PSA is typically prevalent within one or more aspects of a career setting. By this, I mean that it is commonly associated with school studies, university presentations, industry training and job-related presentations. Thus PSA can seriously impact upon an individual's career progression and earning-potential with the risk of the development of mental health issues arising from excessive life-stresses. Despite all this, due to the current difficult economic climate in the UK, PSA alone is not typically regarded as a serious-enough issue to require professional intervention.

My excitement over this revelation grew as it dawned upon me that ACT might not only be both efficacious and readily applicable to the difficulties commonly associated with PSA, but that as a potentially "user friendly" brief intervention being much more accessible than other long-term approaches to PSA management, it offered significant improvement over existing established therapies.

I knew public speaking anxiety was not only quite common within the general population but also for relatively well-educated students. I remember from my own undergraduate years public speaking was a highly daunting task. I would frequently take the avoidance route unless it was compulsory. So with some not-so-pleasant memories of my own personal

experiences of PSA and a strong desire for self-improvement, it seemed to be a natural research avenue to take. That conducting research around the development and implementation of effective interventions with regard to PSA would be a valid exercise with the potential to improve the life-choices of individuals who otherwise might remain significantly disadvantaged due to financial barriers and other life-stressors.

As discussed previously, individuals experiencing PSA typically do not get picked up by professionals and individuals will often under-report (Stien et al., 1996) which means their unhelpful experiences can exacerbate quickly and they may go on to experience long-lasting impacts.

Accessible, potential for cost saving, time efficient, new interventions would be essential. Therefore, the development and provision of well-publicized, easily accessible community based interventions via this study will make new interventions more accessible to this hard to reach groups in the society.

After my aforementioned literature review I realized that ACT had been shown to be successful as a brief format in some psychological difficulties such as anxiety and psychosis using a different delivery format. However there was no study directly comparing the brief ACT-format group to self-help or it seemed that the research in this field was limited especially with regard to exploring public speaking anxiety. So it seemed that I might be able to contribute something to the body of work in this area through development of a brief ACT format for PSA and to try and establish whether the workshop or the self-help-format would be more effective.

Development of the self-help booklet and workshop programme has been a rewarding learning experience. I had thought that the self-directed format could be easily disseminated

to larger populations and would be helpful in increasing accessibility. From a review of the literature I realized that self-help interventions had seemed to be useful in the treatment of anxiety and panic problems together with depression (Hirai & Clum, 2006; Johnson, 2008). On this basis, I thought it would worth trying this out for public speaking anxiety. However, those studies were limited by sample sizes and methodological limitations which had prevented conclusions being drawn about comparisons between the disorders. Thus I am grateful to the ACT community for sharing generously their knowledge and materials made available to be used freely which made my job so much easier. Preparation of my research proposal helped me to expand my knowledge and enhance my literature reviewing skills which also allowed me to develop critical evaluation skills and draw conclusions and develop new research questions.

After obtaining ethical approval, I started advertising the research. The recruitment process proved difficult and took more time than anticipated. Using online screening made it easy to identify participants who met the inclusion criteria. However, retaining participants until study completion was another challenge. Establishing a good rapport with my participants right at the beginning rendered things a bit easier. I tried to be flexible and considerate as many of them were students and had commitments. I aimed to have a larger participants group, however many potential participants were excluded, as they did not meet the criteria or went beyond the cut-off score indicating severe social anxiety. Additionally some people were not eventually able to attend to the workshop due to various reasons. A few people requested to move to the self-help group due to their work/ family commitments, but luckily some individuals were much more flexible so they were happy to move to the workshop group. I did feel extremely frustrated when I was not able to recruit my anticipated target

number; I felt so frustrated and even experienced bouts of panic, thinking that it would adversely impact the power of the analysis.

Organizing the workshops has proven to have been the most difficult part. My initial plan was to organize bigger groups so it would both be more daunting or realistic for the speaking task and time saving too. However, it was not easy to co-ordinate everybody to attend on certain days due to individuals' other commitments. Eventually, by offering more flexibility regarding attendance dates and working around participants other commitments, it was possible to rework and manage the situation satisfactorily.

Despite the challenges described above, I believe that the research exercise was a success especially with regard to the planning, re-working of schedules and managing all the workshops. I feel so grateful to all my participants who were able to take part in this research and especially to those who were able to complete the full programme of exercises and who were retained until the completion of the research.

Developing intervention materials and presentation of the workshops has been a great experience for myself. Modifying existing intervention materials to make them specific to PSA has increased my confidence to consider adapting ACT to other psychological difficulties encountered within my clinical practice.

The presentation of workshops was a learning curve. Despite having watched a few good presentation programs to try and improve my delivery of effective workshops, there is nothing quite like actually doing the work, "walking the walk and talking the talk."

Collecting the raw data was to prove to be another difficult aspect of the research process. I needed to email people several times to remind them to fill the follow-up measures. After

the data collection was completed, the process of data analyses began. This was quite stressful as at times I felt overwhelmed by the data analysis software that I was using for the multi-variate analysis. But with special thanks to Dr Wendy Nicholls, who made this process easier for me, the analysis was completed. Using multivariate analysis has been something of a roller-coaster ride of emotion but as an analytical tool it was the most robust and appropriate analysis. MANOVA allowed the visualization of key effects of the outcome measures and to readily examine interactions among these measures.

Throughout the entire research process, I have faced considerable personal pressures and difficulties. There have been the logistical problems associated with living in Northwest England, at weekends working double-shifts on a busy, adult acute locked psychiatric ward and travelling by train & bus to the West Midlands, during the week to meet with clients, attend multi-disciplinary meetings, write client reports and undertake a demanding research project. It would not be overstating things to say that this period of my life has tested me to the limits of both my physical and mental health.

This has also been a difficult time for me in financial terms, there have been occasions when I have felt financially exploited by "the system." My time is not "free" and yet that how I have frequently felt treated when putting in long unpaid hours. For some it may seem trivial, but that is not the reality. Such feelings and thoughts are not helped either, when for example on one occasion no participants turned up for the workshop for a number of reasons given at the last minute without any warning.

On a brighter note, the ACT therapist is supposed to be practicing what they preach (Strosahl, Hayes, Wilson, & Gifford, 2004). Accordingly I loved the experience of it, I practiced stepping back from overwhelming experiences and learned to become flexible

observer of my experiences. Value clarification has been refreshing and motivated me to move forward despite all the personal hardships. I feel ACT has positively influenced the aspects of my how I approach to life, brought more openness and acceptance which was refreshing and harmonious with my own valued and upbringing.

The participant satisfaction survey was implemented in order to receive feedback from the participants. Positive feedback was received. In an ideal situation it would be nice to add the client satisfaction survey within the analysis. However due to word limit constraints this was not possible.

Overall, the research findings were encouraging as they suggested that an ultra-brief form of ACT was indeed a viable intervention, able to facilitate significant change within a relatively short time. The results are supportive of my belief that ACT offers real benefits as an intervention. The research evidence gives me the confidence to utilize brief-format ACT in my clinical practice with a wide range of clients, carers and health care professionals. Utilization of ACT can be usefully extended to community settings through the establishment of free psychotherapy outreach networks for the marginalized, the underprivileged and other typically hard to reach groups. Given the recent cuts in the NHS services, therapies aimed more directly at community groups who are on low income or government benefits would offer significantly improved access for people who would otherwise struggle to cope with difficulties within their emotional and psychological lives.

As I near my goal of becoming a qualified counselling psychologist, I am ever more certain of my commitment to contribute to improving the quality of emotional life for individuals, their families and the wider communities they represent. In these difficult times, it is increasingly evident that we need to strive harder for real social justice and to actively

promote more positive community values in response to social injustice and cynical market values that seem to have a tightening grip on our society. Through my research and clinical practice over the three years, I do feel more comfortable developing local community projects applying ACT in both a clinical and community settings. Further, to also promote and deploy programmes that extend to in-house staff development, service provision and Trust health policies.

3.1.6 Conclusion

In this critical appraisal I have reflected on my research experience and my interest and enthusiasm for ACT. I have explained how counselling psychology is compatible with ACT. I have explained that utilizing ACT skills in my own life has helped me to learn to sit comfortably with considerable difficulties and to aid moving forward whilst acting out my values and goals. I have discussed why and how the research process has been an invaluable experience in enhancing my research and clinical skills. That I feel my skills are transferable to many research fields and other work areas; that I hope to be able to carry out further quantitative and qualitative research in my clinical practice.

On an academic level I have thoroughly enjoyed the different aspects of my training in counselling psychology. It has been an invaluable experience being able work in diverse and even unique services, to be applying psychological theory to practice and to learn from experiences. This research dossier by no means perfect but I believe it has been a great learning experience for me and I hope it will contribute something useful to the applied psychology field both within clinical and community settings.

Chapter 4

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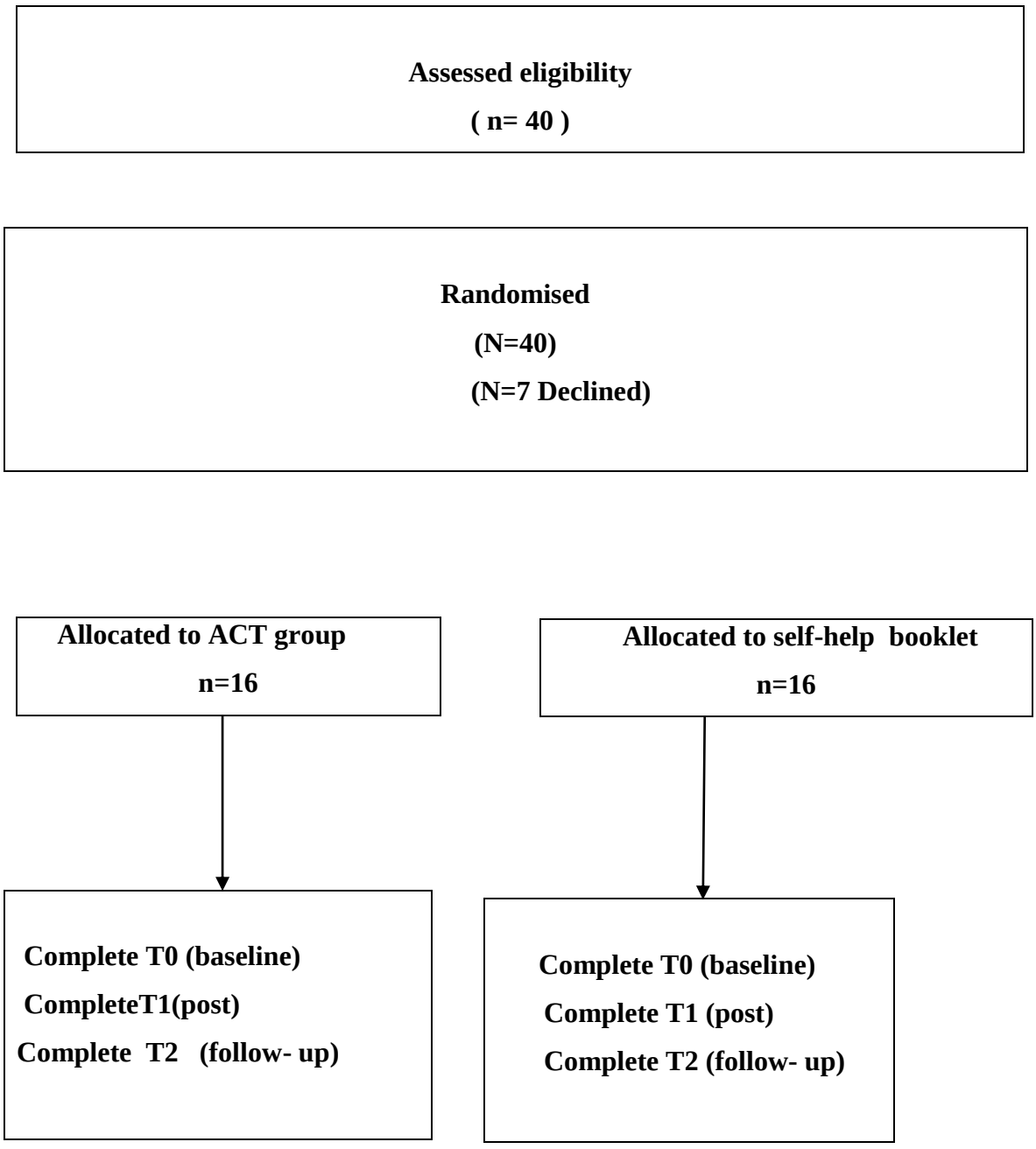
5. APPENDICES

Appendix 1

RESEARCH PROTOCOL



Appendix 2

CONSENT FORM

Title of Project:

Investigating the effectiveness of Ultra brief Acceptance and Commitment skills training: group vs. self-help for people with moderate public speaking anxiety: a randomised controlled trial.

Name of Researcher: Seyla Dogan

Please initial boxes

1. I confirm that I have read and understand the information sheet dated for above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw my data up to the point of data analysis, without giving any reason. (By November 2014) ☐
3. I understand that my data will be stored securely and confidentially and that I will not be identifiable in any report or publication
4. I understand that the researcher may wish to publish this study and any results found, for which I give my permission ☐
5. I agree for my interview to be recorded and for the data to be used for the purpose of this study. ☐
6. I agree to take part in the above study. ☐

…….. …….. ……..

Name Date Signature

……. ……. …….

Researcher Date Sig

Appendix 3

Participant Information Sheet

Study Title: Comparing Ultra-Brief Acceptance & Commitment skills based group intervention and self-help training for public speaking anxiety

You are being invited to take part in a research study. Before you accept it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

About me: My name is Seyla Dogan, I am a trainee counselling psychologist studying at the University of Wolverhampton and am currently working in psychology services in the Midlands. I am in the second year of my training.

Research supervisors and their contact details:

Dr Wendy Nicholls / [e-mail address redacted]

Dr Lee Hulbert, / [e-mail address redacted]

Dr Nick Hulbert Williams / [e-mail address redacted]

What is the purpose of the study?

As doctorate students we are required to complete a substantial piece of research in our area of interest. The purpose of the study is to investigate how well ultra-brief acceptance and commitment training works to help people with a fear of public speaking. Acceptance and

commitment training utilizes a range of skills to help people to accept unhelpful feelings and emotions that may be encountered during public speaking.

Why have I been chosen?

You have declared some anxiety regarding speaking in public. Approximately 50 participants who have expressed similar fears will be recruited for this research. The study will last for 3 consecutive weeks; around one month afterwards you will be contacted via e-mail and will be asked to fill out a final set of questionnaires.

Do I have to take part?

Taking part in the research is entirely voluntary. It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw your data without giving any reason, up to the point of analysis (By November 2014)or to have your score data removed after the study has concluded.

What will happen if I decide to take part?

You are being asked to participate in a research study designed to help you with mild public speaking anxiety such as may occur when giving an oral presentation in class.

You will be asked to sign the consent form and to complete a set of questionnaires about anxiety-provoking and evaluative situations. This process will be in three stages – (i) before the study takes place; (ii) after the study has finished and (iii) 1 month later. This will help to assess if you have found the acceptance and commitment techniques helpful.

You may choose to skip questions and/or discontinue at any time. After completing the questionnaires you may be invited to participate in a three-session workshop which will last

1 hour each, in total 3 hrs or to receive a self-help workbook based on acceptance and commitment training.

This training will help you to develop skills to cope with public speaking anxiety. You will be encouraged to practice these skills on a daily basis if you are able.

The acceptance and commitment training workshop will include a total of three sessions over consecutive weeks, and after one month you will be contacted via email and be asked to fill out the same questionnaires to assess if those learnt techniques are still helpful.

The participants who are assigned to the self-help group will be given/emailed a self-help workbook prepared by the researcher which will consist of the same materials as in the group workshops and they will be asked to read the material, work through each page at a time, completing the exercises over a period of one month.

You may keep the information form and a copy of your consent form. Some of the group sessions may be audio-recorded for the purpose of supervision and independent evaluation. No one other than research staff / examiners will have access to these tapes. If you are not willing to give consent for the audio recording this will not affect your participation in the group training program.

To obtain the full benefit of this workshop we strongly encourage you to participate in the three sessions and practice the skills/techniques covered in the workshop. To obtain the full benefit of the self-help workbook we encourage you to read through the three modules, complete the exercises and practice the learned skills covered in the workbook. However, you are free to leave at any time.

What are the potential benefits and risks of taking part?

There are no risks to you in taking part outside of those you would experience in everyday life. However, if you feel that your anxiety increases please talk to the researcher. If you find things upsetting, the researcher will ask you if you wish to continue to participate in the research. Any decision you make will be respected. The potential benefits of the study are that you will learn skills to help you with your fear and to become more confident in speaking in public.

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in this study will be used for research purpose only and will be kept confidential. Only the researchers/supervisors and examiners (if requested) working on the project will have access to the information. However, such personnel will be unable to identify participants, as the data will be anonymised by using codes on the questionnaires.

Some group sessions will be audio-taped and analyzed for the purpose of independent evaluation and research purposes. No one other than research staff/ supervisors/ examiners will have access to these tapes. These audiotapes will be destroyed after completion of the study. If you are not willing to give consent for audio taping your exercises, this will not affect your participation in the workshop training. You will not be identifiable in any publication or report as the data will be grouped together and all identifying information will be removed. All data and contact details will be collected by the researcher, saved on a password protected computer and once the study is completed this data will be destroyed. The findings from the study may be published in a journal article or conference paper, but you will not be individually identifiable.

What will happen at the end of the research study?

I will analyze the data and write up my research report, there is a possibility that it might be published, If you wish I can provide you with a summary of my findings and a copy of the published results. So please let me know if you would like to obtain a copy / or have any questions or concerns about any aspect of the research.

What if I have a problem or concern?

If you have a concern about any aspect of this study, please do not hesitate to ask me or my research supervisors; we will do our best to answer your questions.

Who has reviewed the study?

Wolverhampton University Research Ethics Committee and Chester University Research Ethics Committee have reviewed the study.

Co**ntact for further information**

My contact details: Seyla Dogan, Wolverhampton University

Email: [e-mail address redacted]

Supervisor's contact details

Dr Wendy Nicholls: [e-mail address redacted]

Dr Lee Hulbert Williams: [e-mail address redacted]

Dr Nick Hulbert Williams: [e-mail address redacted]

The date of the study:

Time:

Rooms for the workshop sessions:

Appendix 4

Email/ Announcement Title:

Does speaking in class or talking in front of people terrify you? Would you like to learn new skills to manage those feelings? If yes then participate in our research.

Dear all,

You are being invited to take part in a research study on moderate public speaking anxiety. If you would be interested in taking part, please email me or forward to other individuals.

The aim of the study is to investigate how well ultra-brief acceptance and commitment training works with people who have moderate fear of public speaking. Acceptance and Commitment techniques are an evidenced based intervention utilize a range of skills to help people to accept feelings and emotions, while moving towards to their valued life.

The study involves attending total 3 hours (1hr each in consecutive weeks) acceptance and commitment training workshop or receiving self-help booklet to help you with your fear of public speaking. You will be asked to complete a number of questionnaires for you to tell us whether the techniques are helpful.

About me:

My name is Seyla Dogan, I am a Counselling Psychologist in training at the Wolverhampton University and am currently working in psychology services in the Midlands. I am at the second year of my training.

Best wishes,

Seyla Dogan

Counselling Psychologist in training

[e-mail address redacted]

Appendix 5

Participant Satisfaction Survey

1. The difficulties (re public speaking anxiety) that brought me to workshop/self help booklet are:

1. Much improved
2. Improved
3. About the same
4. Worse
5. Much worse

2. The facilitator was:

1. Very helpful
2. Somewhat helpful
3. Neither helpful or Unhelpful
4. Somewhat unhelpful
5. Very unhelpful

3. The workshop provided me with the satisfactory skills and topics were adequately explained.

1. Very Satisfied
2. Satisfied
3. Neutral
4. Dissatisfied
5. Very Dissatisfied

4. I would recommend this workshop to others who need help:

1. Definitely
2. Probably
3. Probably not

4. Definitely not

I would appreciate any other comments that you would like to share.

.....

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.....

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Best Wishes,

Seyla Dogan

Wolverhampton University

Doctorate in Counselling psychology

[e-mail address redacted]

APPENDIX 6

MEASURES AAQ-II ACCEPTANCE AND ACTION QUESTIONNAIRE REVISED VERSION

Below you will find a list of statements. Please rate how true each statement is for you by circling a number next to it. Use the scale below to make your choice.

1	**2**	**3**	**4**	**5**	**6**	**7**
never true	**very seldom true**	**seldom true**	**sometimes true**	**frequently true**	**almost always true**	**always true**

1.	My painful experiences and memories make it difficult for me to live a life that I would value.	1	2	3	4	5	6	7
2.	I'm afraid of my feelings.	1	2	3	4	5	6	7
3.	I worry about not being able to control my worries and feelings.	1	2	3	4	5	6	7
4.	My painful memories prevent me from having a fulfilling life.	1	2	3	4	5	6	7
5.	Emotions cause problems in my life.	1	2	3	4	5	6	7
6.	It seems like most people are handling their lives better than I am.	1	2	3	4	5	6	7
7.	Worries get in the way of my success.	1	2	3	4	5	6	7

Bond, F. W., Hayes, S. C., Baer, R. A., Carpenter, K. C., Guenole, N., Orcutt, H. K., Waltz, T. and Zettle, R. D. (2011). Preliminary psychometric properties of the Acceptance and Action Questionnaire – II: A revised measure of psychological flexibility and acceptance. *Behavior Therapy*, *42*, 676-

Appendix 7

Social Interaction Anxiety Scale SIAS

Mattick & Clark, 1989

Instructions

In this section, for each item, please circle the number to indicate the degree to which you feel the statement is characteristic or true for you. *The rating scale is as follows:*

0 = **Not at all** characteristic or true of me.
1 = **Slightly** characteristic or true of me.
2 = **Moderately** characteristic or true of me.
3 = **Very** characteristic or true of me.
4 = **Extremel**y characteristic or true of me

	Characteristic	**Not at all**	**Slightly**	**Moderately**	**Very**	**Extremely**
01.	I get nervous if I have to speak with someone in authority (teacher, boss).	0	1	2	3	4
02.	I have difficulty making eye contact with others.	0	1	2	3	4
03.	I become tense if I have to talk about myself or my feelings.	0	1	2	3	4
04.	I find it difficult to mix comfortably with the people I work with.	0	1	2	3	4
05.	I find it easy to make friends my own age.	0	1	2	3	4
06.	I tense up if I meet an acquaintance in the street.	0	1	2	3	4
07.	When mixing socially, I am uncomfortable.	0	1	2	3	4
08.	I feel tense when I am alone with just one person.	0	1	2	3	4
09.	I am at ease meeting people at parties, etc.	0	1	2	3	4
10.	I have difficulty talking with other people.	0	1	2	3	4
11.	I find it easy to think of things to talk about.	0	1	2	3	4

12.	I worry about expressing myself in case I appear awkward.	0	1	2	3	4
13.	I find it difficult to disagree with another's point of view.	0	1	2	3	4
14.	I have difficulty talking to attractive persons of the opposite sex.	0	1	2	3	4
15.	I find myself worrying that I won't know what to say in social situations.	0	1	2	3	4
16.	I am nervous mixing with people I don't know well.	0	1	2	3	4
17.	I feel I'll say something embarrassing when talking.	0	1	2	3	4
18.	When mixing in a group, I find myself worrying I will be ignored.	0	1	2	3	4
19.	I am tense mixing in a group.	0	1	2	3	4
20.	I am unsure whether to greet someone I know only slightly.	0	1	2	3	4

Appendix 8

WILLINGNESS

Listed below are several public speaking situations. Please circle a number to indicate how willing you are to engage in each of these public speaking activities (1 = completely unwilling; 10 = completely willing).

3-4 people) to ask a question or make a comment?	1	2	3	4	5	6	7	8	9	10
Raising your hand in a large classroom setting (e.g., 30-50 people) to ask a question or make a comment?	1	2	3	4	5	6	7	8	9	10
Raising your hand in a lecture centre (LC) to ask a question or make a comment?	1	2	3	4	5	6	7	8	9	10
Giving a presentation in a small seminar class?	1	2	3	4	5	6	7	8	9	10
Giving a presentation in a large classroom setting?	1	2	3	4	5	6	7	8	9	10
Giving a presentation in an LC?	1	2	3	4	5	6	7	8	9	10
Approaching a lecturer during office hours to speak with him/her personally?	1	2	3	4	5	6	7	8	9	10
Approaching a professor during office hours to speak with him/her personally?	1	2	3	4	5	6	7	8	9	10

Wulfert, E., Block, J. (1998). Willingness Scale

Appendix 9

Valued Living Questionnaire (Kelly Wilson 2002)

Below are domains of life that are valued by some people. We are concerned with your subjective experience of your quality of life in each of these domains. One aspect of quality of life involves the importance one puts on the different domains of living. Rate the importance of each domain (by circling a number) on a scale of 1-10. 1 means that domain is not at all important and 10 means that domain is very important. Not everyone will value all of these domains, or value all domains the same. Rate each domain according to your own personal sense of importance.

Domain: 1: **not at all important / 10: extremely important**

1. Family relations (other than marriage or parenting)

   1 2 3 4 5 6 7 8 9 10

2. Marriage/couples/intimate relations

   1 2 3 4 5 6 7 8 9 10

3. Parenting

   1 2 3 4 5 6 7 8 9 10

4. Friendships/social relations

   1 2 3 4 5 6 7 8 9 10

5. Employment

1 2 3 4 5 6 7 8 9 10

6. Education/training

1 2 3 4 5 6 7 8 9 10

6. Recreation

1 2 3 4 5 6 7 8 9 10

8. Spirituality

1 2 3 4 5 6 7 8 9 10

9. Citizenship/Community Life

1 2 3 4 5 6 7 8 9 10

10. Physical well-being

1 2 3 4 5 6 7 8 9 10

(Continued appendices 9)

Valued Living Questionnaire Psychometrics 34

In this section, we would like you to give a rating of how consistent your actions are with each value. Everyone does better in some domains than others. We are NOT asking about your ideal in each domain. We want to know how you think you have been doing during the past week.

Rate each item (by circling a number) on a scale of 1-10. 1 means that your actions have been fully inconsistent with your value and 10 means that your actions have been fully consistent with your value.

During the past week

Domain 1: **not at all consistent / 10: extremely consistent**

1. Family relations (other than marriage or parenting)

1 2 3 4 5 6 7 8 9 10

2. Marriage/couples/intimate relations

1 2 3 4 5 6 7 8 9 10

3. Parenting

1 2 3 4 5 6 7 8 9 10

4. Friendships/social relations

1 2 3 4 5 6 7 8 9 10

5. Employment

1 2 3 4 5 6 7 8 9 10

6. Education/training

1 2 3 4 5 6 7 8 9 10

7. Recreation

1 2 3 4 5 6 7 8 9 10

8.Spirituality

1 2 3 4 5 6 7 8 9 10

9. Citizenship/Community Life

1 2 3 4 5 6 7 8 9 10

10. Physical well-being

1 2 3 4 5 6 7 8 9 10

Appendix 10

Debrief Sheet

Thank you for taking part in this study.

The purpose of the study was to investigate how well ultra-brief acceptance and commitment training works to help people with a fear of public speaking.

All data about your participation in this study will be used for research purpose only and will be kept confidential. Only the researchers/supervisors and examiners working on the project will have access to the information and even they will not be able to identify participants. Codes within the questionnaires ensure all participants will be anonymous.

You may withdraw your data from the study for any reason up to the point of data analysis by contacting the researcher (By November 2014).
If you wish to obtain a copy of the research report please contact the researcher and this will be made available to you.

The researcher's details:

Seyla Dogan
Wolverhampton University
Doctorate in Counselling Psychology
[e-mail address redacted]

Appendix 11

Personal Report of Confidence as a Speaker Scale PRCS/ Hook, Smith &Valentiner, 2008)

In this section, for each item, please circle the number to indicate the degree to which you feel the statement is true for you.

Characteristic	**1 Strongly agree**	**2 Agree**	**3 Neutral**	**4 Disagree**	**5 Strongly disagree**
1.My hands tremble when I try to handle objects on the platform	1	2	3	4	5
2. I am in constant fear of forgetting my speech	1	2	3	4	5
3. While preparing a speech I am in a constant state of anxiety	1	2	3	4	5
4. My thoughts become confused and jumbled when I speak before the audience	1	2	3	4	5
5. Although I talk fluently with friends I am at a loss for words on the platform.	1	2	3	4	5
6. The faces of my audience are blurred when I look at them	1	2	3	4	5
7.I feel disgusted with myself after trying to address a group of people	1	2	3	4	5
8. I perspire and tremble just before getting up to speak	1	2	3	4	5
9. My posture feels strained and unnatural	1	2	3	4	5
10. I am fearful and tense all the while I am speaking before a group of people.	1	2	3	4	5
11. It is difficult for me to search my mind calmly for the right words to express my thoughts	1	2	3	4	5
12. I am terrified at the thoughts of speaking before a group of people	1	2	3	4	5

Appendix 12

Fear of Public Speaking
Acceptance and Commitment Trainer`s Manual

Seyla Dogan
Wolverhampton University

Supervised by
Dr Wendy Nicholls
Dr Lee Hulbert Williams
Dr Nick Hulbert-Williams

Acceptance and Commitment training Workshop Trainer`s Manual

The ACT protocol materials were taken from the below books and official ACT website www.contextualscience.org. Permissions were obtained to use the materials, these materials are published under a creative commons license and are made available for research purposes.

Acceptance and Commitment Therapy: An Experiential Approach to Behaviour Change (1999). Hayes, Strosahl, & Wilson. Guilford Press.

Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy (2005). Hayes and Smith. New Harbinger.

The Mindfulness & Acceptance Workbook for Anxiety (2007). Eifert, G. H., & Forsyth, J. P. (2007). Oakland, New Harbinger Publications

ACT Made Simple (2009). Russ Harris, New Harbinger Publications

Mindfulness and Acceptance-based group therapy for social anxiety disorder. Kocovski, N. L., Fleming, J. E., & Rector, N. A. (2009). Cognitive and Behavioral Practice, 16, 276-289.

Session 1:

Administer questionnaires AAQ/ PRCS /willingness /Valued Living before session starts

Objectives:

- Introduction/program overview
- Confidentiality
- Administer questionnaires AAQ/ Valued directions/willingness
- Understanding the participants' experiences of public speaking anxiety (Life path questions Stroshal et al 2012)
- Unworkable agenda /control is the problem
- Alternative Openness/acceptance
- Solicit Identifying values

Possible strategies:

- Polygraph metaphor
- Quicksand metaphor (Hayes et al, 1999)
- Passengers on the bus
- Pink elephant
- Stop feeding the anxiety tiger
- Compass metaphor
- Two kids on the car
- Participants to generate a list of opportunities for public speaking practice in their daily lives and to choose one of these each week as a homework assignment

Homework:

- Identify values/goals with regards to public speaking anxiety/ keep your values at the forefront when engaging in valued, anxiety provoking activities.
- Practise one of your chosen public speaking task/ monitor experience of struggle (Notice your passengers on your bus and observe this experience)

Session 2:

Objectives:

- Homework overview
- Promote Openness, acceptance and mindfulness
- Defusion (developing different relationship with thoughts)

Possible strategies

- Mindful eating (Morris & Johns & Byrne2012)
- Defusion techniques
- Guided imagery : Observing /accepting mindful breathing exercise (Forsyth & Eifert 2012)
- Read Leaves on a stream metaphor (Russ Harris 2009 p, 113, Hayes & Smith 2005
- Ask participants to briefly summarise what they understand the main points

Homework

- Practise one of their chosen public speaking situation e.g.
- Practice defusion techniques when you notice your passengers
- Read mountain exercise
- Read accepting anxious thoughts and feelings exercise (Forsyth & Eifert 2012)
- Do one mindful activity a day

Session 3

Administering questionnaires before session starts

Objectives

- Homework overview, any questions
- Mindfulness exercise (Eiffert & Fosytsth et al 2007)
- Exposure to feared situation
- Filling questionnaires
- Arrange post intervention assessments
- Reflections/moving toward valued life

Possible strategies

- Acceptance of anxious feelings exercise (Eiffert & Fosytsth 2007 p, 198)
- 5-10 min speech of chosen subject
- Ask participants to briefly summarize the main points
- Ask participants each day to choose one or more of the exercises they completed in this group work
- Schedule post intervention evaluation

Thanks for participation

SELECTED ACT METAPHORS / HANDOUT 1

Two kids in the car metaphor (Harris 2007, p 194)

Imagine there are two kids in the back of a car and mom is driving them to the Disneyland. It is three hours trip to get there and one of kid is saying: are we there yet mom? Are we there yet? Are we there yet?

Mom is getting annoyed, kid is frustrated. They are snapping at each other. But the other kid is looking out of the window, waving at the other cars, noticing with great interest all the towns, mountains, farms factories that they are driving past. Now both kids reached to the Disneyland at the same time and both have a great time when they get there

Only one kid has had the rewarding journey why?

Passengers on the Bus (Hayes and Smith 2005)

Suppose you commit yourself to drive a small busload of children to the fairground. You were planning to on going to the fairground anyway and thought you would help out. Imagine that after you commit yourself to the trip out, its organizer informs you that little Jonny Boogernose, the meanest, nastiest kid in the bunch, will be riding with you. Still you said you would transform a load of children, so you head off to the state fair. Several miles away imagine, the kids started fighting , so you pull to the side of the road and inform them you won't go any further until they shut up and behave themselves , notice though what happens when you do that? Who is in control of whether or you make it to the fair? Is it you or rowdy kids? What if they never shut up? Do you see that your choice to go to the fair has now transformed into a decision that is out of your hand? You are stuck are you prepared to spend your rest of life pulled over to the side imagine the rowdy kids, even little Jonny Buggernose himself are your thoughts feelings, memories that you want them to shut up. And you are on a life journey are you going to choose the direction you take or are you going to let your thoughts and feelings decide for you?

(Zettle & Hayes, Brief ACT for depression as in Bond & Dryden et al 2002 p, 47)

Seeing Thoughts as Thoughts Worksheet

This new way of relating to thoughts might take some time to get used to, so it is recommended you practice, practice and more practice.

List some of the thoughts that typically show up in each of your feared situation and use these new techniques.

Thoughts **e.g. "I am boring"**	**Seeing thoughts as thoughts** ***e.g. I am having the thought that "I am boring"***	**What did you notice** ***e.g. I had the thought but still contributed to the conversation***

REFLECTIONS

- After this exercise what did you notice?
- Were you better to see the thought as thought?
- Did the believability of thoughts go down?
- Did the distress cause by the thought reduce

Please each day choose one or more of the exercises you completed in this workbook

Mindfulness Activity

Mindfulness exercise	**Comment e.g. barriers, were you able to utilise mindfulness and acceptance**

Handout session 2

Mindful breathing exercise / Guided imagery mindful breathing exercise (Adapted from Forsyth& Eifert 2012 book p: 145)

Aim: This exercise is wonderful way to cultivate your observer mind. Allow yourself to practice the mindful breathing exercise at least one each day.
Start by getting yourself comfortable in a place where you will be undisturbed for five to 10 min. You may sit on a floor on a chair or sit upright with your palms up or down on your lap. Close your eyes or fix them on a point in front of you. And gently guide your attentions to the natural rhythm of your breath in your chest and belly. Notice the sensations of breathing in (pause). And notice the sensations of breathing out (pause). You might notice the air moving in through your mouth or nose. You might notice the sensations of the air moving out [pause]. Notice the feeling of your chest rising and falling. As you do this you might notice your mind drift away from noticing your breathing – if that happens, acknowledge where your mind took you and gently bring it back to your breathing [pause]. Next, bring your attention to the sensation of sitting the chair. Notice where your feet touches the ground [pause 5-10 seconds] Notice where parts of your feet don't touch the ground [pause 5-10 seconds]? Next, notice the sensation of sitting in the chair and see if you can notice the sense of your weight on the chair [pause 5-10 seconds]. Maybe notice where parts of your body contact the chair. Notice where your body doesn't contact the chair [pause 5-10 seconds]. Next, move your attention inside your body. See if you can notice any physical sensations or feelings, such as a tight muscle or an area of tension [pause 5-10 seconds]. Pick one of these and direct your attention there [pause 5-10 seconds]. Examine it with a sense of curiosity. Where does it start? Where does it end [pause 5-10 seconds]? See if you can observe it without trying to change it [pause 5-10 seconds]. Spend a bit of time just noticing this sensation or feeling [pause 5-10 seconds]. As you do this, it might increase. It might decrease. It might stay just the same. Just notice this [pause 5-10 seconds]. Lastly, bring your attention back to your breathing [pause 5-10 seconds]. Notice again the steady rhythm of your breathing that is with you all the time [pause 5-10 seconds].
When you are ready, open your eyes if they are closed and come back into the room.

How you found this exercise? What did you notice?

.....
.....
.....
.....
.....

Session 2 Handout

Acceptance of anxious feelings (*Eifert and Forsyth, 2005, p.163-166)*

In this exercise, we will actively and openly invite anxiety into our awareness so that we can practice approaching it in an accepting way. Just as we stopped feeding the anxiety tiger, letting the passengers come and go this exercise encourages us to *lean into* anxiety rather than fight it.

So get into a comfortable position in your chair. Sit upright with feet flat on the floor, arms and legs uncrossed, and hands resting in the lap (palms up or down, whichever is more comfortable). Allow the eyes to close gently [pause 10 seconds].

Now take a few moments to get in touch with the physical sensations in the body, especially the sensations of touch or pressure where the body makes contact with the chair or floor. Notice the gentle rising and falling of the breath in the chest and belly. No need to control the breathing in any way—simply let the breath breathe itself [pause 10 seconds]. As best you can, also bring this attitude of allowing and gentle acceptance to the rest of your experience. There is nothing to be fixed. Simply allow your experience to be your experience, without needing it to be other than what it is [pause 10 seconds].

Notice thoughts and feelings; acknowledge their presence, and staying with them [pause 10 seconds]. No need to think of something else, make them go away, or resolve anything. As best you can, allowing them to be … give yourself space to have whatever you have … bring a quality of kindness and compassion to your experience [pause 10 seconds].

Now allow yourself to be present to what you are afraid of. Notice any fears and worries. Perhaps fear of being judged negatively, worry about making a bad impression. Whatever the fear is, just acknowledge its presence, not working on it [pause 10 seconds]. Now see if for just a moment you can be present with your values and goals. Ask yourself, Why am I here? Where do I want to go? What do I want to do? [pause 15 seconds]

Now bring to mind a public speaking situation that has been difficult for you. It could be a situation in the past, the present, or the future [pause 10 seconds]. Now, with this situation in mind, notice any strong feelings or sensations that may arise in your body, allow them to be as they are rather than what you think they are, and simply hold them in awareness [pause 10 seconds]. Stay with the discomfort and breathing with it [pause 10 seconds].

Gently open up to it and making space for it, accept and allow it to be [pause], bring compassionate and focused attention to the sensations of discomfort [pause 15 seconds].

If you notice yourself tensing up and resisting what you have, pushing away from the experience, acknowledge that and see if you can make some space for whatever you're experiencing [pause 10 seconds]. Must these feelings be your enemy? [pause 10 seconds] Or can you have them, notice them, own them, and let them be? [pause 10 seconds]

Can you make room for the discomfort, the tension, the anxiety? [pause 10 seconds] What does it really feel like—moment to moment? [pause 10 seconds] Is this something you *should* struggle with or can you invite the discomfort in, saying to yourself with willingness, "Let me have it; let me feel what there is to be felt because it is my experience right now"? [pause 15 seconds] Along with feelings and physical sensations in the body, you may also notice thoughts coming along, and thoughts about thoughts. Can you invite them in . . . softening and opening to them as you become aware of them [pause 10 seconds]. The mind may also come up with evaluative labels such as "dangerous" or "getting worse." If that happens, you can simply thank your mind for the label [Pause 10 sec]. seconds] and return to the present experience as it is, not as your mind says it is, noticing thoughts as thoughts, physical sensations as physical sensations, feelings as feelings—nothing more, nothing less [pause 15 seconds].

Now let go of thoughts, feelings and sensations and directing your focus back to the breath. [pause 15 seconds].

Then, when you are ready, gradually widen your attention to take in the sounds in this room [pause 10 seconds]. Take a moment to make the intention to bring this sense of gentle allowing and self-acceptance into the present moment [pause 5 seconds], and when you are ready, slowly opening your eyes.

How did you experience this exercise?

……
……
……

Appendix 13

SPSS Output

SYNTAX INITIAL CALCULATIONS

**********BASELINE /POST CALCULATIONS **********

******RECODES/REVERSING**********

DATASET ACTIVATE DataSet1.

RECODE SIAS_Q5B SIAS_Q9B SIAS_Q11B SIAS_Q5P SIAS_Q9P SIAS_Q11P (0=4) (1=3) (2=2) (3=1) (4=0)

(MISSING=Copy) INTO SIAS_Q5Br SIAS_Q9Br SIAS_Q11Br SIAS_Q5Pr SIAS_Q9Pr SIAS_Q11Pr.

EXECUTE.

********** BASELINE TOTALS**********

COMPUTE SIASBASELINET=SUM(SIAS_Q1B,SIAS_Q2B,SIAS_Q3B,SIAS_Q4B,SIAS_Q6B, SIAS_Q7B,SIAS_Q8B,SIAS_Q10B,

SIAS_Q12B,SIAS_Q13B,SIAS_Q14B,SIAS_Q15B,SIAS_Q16B,SIAS_Q17B,SIAS_ Q18B,SIAS_Q19B,SIAS_Q20B,SIAS_Q5Br,

SIAS_Q9Br,SIAS_Q11Br).

EXECUTE.

COMPUTE VALUEBASELINET=MEAN.8(ValueQ1B,ValueQ2B,ValueQ3B,ValueQ4B,ValueQ5 B,ValueQ6B,ValueQ7B,ValueQ8B,

ValueQ9B,ValueQ10B).

EXECUTE.

```
COMPUTE
AAQBASELINET=SUM(AAQ_Q1B,AAQ_Q2B,AAQ_Q3B,AAQ_Q4B,AAQ_Q5B,
AAQ_Q6B,AAQ_Q7B).

EXECUTE.

COMPUTE
WILLINGNESSBT=SUM(Will_Q1B,Will_Q2B,Will_Q3B,Will_Q4B,Will_Q5B,Will
_Q6B,Will_Q7B,Will_Q8B).

EXECUTE.

COMPUTE
PRCSBASELINET=SUM(PRCS_Q1B,PRCS_Q2B,PRCS_Q3B,PRCS_Q4B,PRCS_Q
5B,PRCS_Q6B,PRCS_Q7B,PRCS_Q8B,

PRCS_Q9B,PRCS_Q10B,PRCS_Q11B,PRCS_Q12B).

EXECUTE.

COMPUTE
VALUE34BASELINET=MEAN.8(Value34Q1B,Value34Q2B,Value34Q3B,Value34Q
4B,Value34Q5B,Value34Q6B,

Value34Q7B,Value34Q8B,Value34Q9B,Value34Q10B).

EXECUTE.

**********************************************************POST
INTERVENTION                                                    TOTALS
**********************************************************************
**********************************************

COMPUTE
SIASpostT=SUM(SIAS_Q1P,SIAS_Q2P,SIAS_Q3P,SIAS_Q4P,SIAS_Q6P,SIAS_Q7
P,SIAS_Q8P,SIAS_Q10P,SIAS_Q12P,SIAS_Q13P,SIAS_Q14P,SIAS_Q15P,SIAS_Q
16P,SIAS_Q17P,SIAS_Q18P,SIAS_Q19P,SIAS_Q20P,SIAS_Q5Pr,SIAS_Q9Pr,SIAS
_Q11Pr).

EXECUTE.
```

```
COMPUTE
AAQpostT=SUM(AAQ_Q1P,AAQ_Q2P,AAQ_Q3P,AAQ_Q4P,AAQ_Q5P,AAQ_Q6
P,AAQ_Q7P).

EXECUTE.

COMPUTE
WILLINGNESSpostT=SUM(Will_Q1P,Will_Q2P,Will_Q3P,Will_Q4P,Will_Q5P,Wil
l_Q6P,Will_Q7P,

 Will_Q8P).

EXECUTE.

COMPUTE
PRCSpostT=SUM(PRCS_Q1P,PRCS_Q2P,PRCS_Q3P,PRCS_Q4P,PRCS_Q5P,PRCS
_Q6P,PRCS_Q7P,PRCS_Q8P,

 PRCS_Q9P,PRCS_Q10P,PRCS_Q11P,PRCS_Q12P).

EXECUTE.

COMPUTE
VALUE34postT=MEAN.8(Value34Q1P,Value34Q2P,Value34Q3P,Value34Q4P,Valu
e34Q5P,Value34Q6P,

Value34Q7P,Value34Q8P,Value34Q9P,Value34Q10P).

EXECUTE.

COMPUTE
VALUEQpostT=MEAN.8(ValueQ1P,ValueQ2P,ValueQ3P,ValueQ4P,ValueQ5P,Valu
eQ6P,ValueQ7P,ValueQ8P,

ValueQ9P,ValueQ10P).

EXECUTE.

**********************************************************************RECO
DING FOLLOW UP CALCULATIONS
**********************************************************************
```

```
RECODE SIAS_Q5_F SIAS_Q9_F SIAS_Q11_F (0=4) (1=3) (2=2) (3=1) (4=0) INTO
SIAS_Q5_follow_R

 SIAS_Q9_follow_R SIAS_Q11_follow_R.

EXECUTE

**********************************************************FOLLOW UP-
UPTOTALS**********************************************************

COMPUTE
WILL_Follow_TOTAL=SUM(WILL_Q1_F,WILL_Q2_F,WILL_Q3_F,WILL_Q4_F,
WILL_Q5_F,WILL_Q6_F,WILL_Q7_F,

 WILL_Q8_F).

EXECUTE.

COMPUTE

PRCS_Follow_T=SUM(PRCS_Q1_F,
PRCS_Q2_F,PRCS_Q3_F,PRCS_Q4_F,PRCS_Q5_F,PRCS_Q6_F,PRCS_Q7_F,

PRCS_Q8_F,PRCS_Q9_F,PRCS_Q10_F,PRCS_Q11_F,PRCS_Q12_F).

EXECUTE.

COMPUTE
VALUE_Follow_Total=MEAN.8(VALUE_Q1_F,VALUE_Q2_F,VALUE_Q3_F,VAL
UE_Q4_F,VALUE_Q5_F,VALUE_Q6_F,

VALUE_Q7_F,VALUE_Q8_F,VALUE_Q9_F,VALUE_Q10_F).

EXECUTE.

COMPUTE VALUE34_Follow_Total=MEAN.8(VALUE_34_Q1_F,


VALUE_34_Q2_F,VALUE_34_Q3_F,VALUE_34_Q4_F,VALUE_34_Q5_F,VALUE
_34_Q6_F,VALUE_34_Q7_F,VALUE_34_Q8_F,

VALUE_34_Q9_F,VALUE_34_Q10_F).

EXECUTE.
```

COMPUTE
AAQ_Follow_Total=SUM(AAQ_Q1_F,AAQ_Q2_F,AAQ_Q3_F,AAQ_Q4_F,AAQ_Q5_F,AAQ_Q6_F,AAQ_Q7_F).

EXECUTE.

COMPUTE
SIAS_Follow_Total=SUM(SIAS_Q1_F,SIAS_Q2_F,SIAS_Q3_F,SIAS_Q4_F,SIAS_Q6_F,SIAS_Q7_F,SIAS_Q8_F,

SIAS_Q10_F,SIAS_Q12_F,SIAS_Q13_F,SIAS_Q14_F,SIAS_Q15_F,SIAS_Q16_F,SIAS_Q17_F,SIAS_Q18_F,SIAS_Q19_F,

SIAS_Q20_F,SIAS_Q5_follow_R,SIAS_Q9_follow_R,SIAS_Q11_follow_R).

EXECUTE.

Syntax /Final MANOVA ANALYSIS

GLM PRCSBASELINET PRCSpostT PRCS_Follow_T VALUEBASELINET VALUEQpostT VALUE_Follow_Total

SIASBASELINET SIASpostT SIAS_Follow_Total VALUE34BASELINET VALUE34postT VALUE34_Follow_Total

WILLINGNESSBT WILLINGNESSpostT WILL_Follow_TOTAL AAQBASELINET AAQpostT AAQ_Follow_Total BY

intervention_type

/WSFACTOR=Time 3 Polynomial

/MEASURE=PCRS VALUE SIAS VALUE34 WILLINGNESS AAQ

/METHOD=SSTYPE(3)

/POSTHOC=intervention_type(GH)

/PLOT=PROFILE(Time*intervention_type)

/EMMEANS=TABLES(OVERALL)

/EMMEANS=TABLES(intervention_type) COMPARE ADJ(BONFERRONI)

/EMMEANS=TABLES(Time) COMPARE ADJ(BONFERRONI)

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/EMMEANS=TABLES(intervention_type*Time)
/PRINT=DESCRIPTIVE ETASQ OPOWER HOMOGENEITY
/CRITERIA=ALPHA(.05)
/WSDESIGN=Time
/DESIGN=intervention_type.
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